**Adult Planned Respite Allocation Form**

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| Person’s name:  |
| DOB: dd/mm/yyyy NHI: |
| Gender: Male Female Other / Non-binary Ethnicity: |
| Address: |
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| Phone (Landline): Phone (cell): |
| Email Address: Preferred method of contact: |
| Contact Person - details: [name / relationship to patient / phone number] |

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| **For GPs only:- Referrer Name: Phone:****Fax:- Email:**  |

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| For SMHS only:- Referrer Name: Phone: |
| Regular Case Manager (if different from referrer): |
| Sector/Specialist Team: |

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| DIAGNOSIS: (Mental Health): |
|  (Physical - *relevant*): |

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| ALLOCATION: [It is recommended the usual allocation of planned respite days *per 12 month period* be 10 – 14 days, with a maximum of 28 days.] |
| No. of days allocated: -  | **For year beginning: - dd/mm/yyyy**  |
| Goals for respite: |

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| Support Plan: Does the person require specific support with (or monitoring) in any of the following areas? If any are required – please specify required actions where appropriate. |
| 🞏 Sleep Pattern: |
| 🞏 Eating/drinking: |
| 🞏 Smoking cessation: |
| 🞏 Physical Needs (e.g. special diet, access/mobility reqts, allergies): |
| 🞏 Safety/self-harm: |
| 🞏 Mood: |
| 🞏 Other: |

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| Risk Factors: (If YES – please specify) |
| Potential Risk | **Y/N** | **Comments** |  |
| History of self-harm / attempted suicide? |  |  |  |
| History of alcohol/drug abuse? |  |  |  |
| History of fire setting? |  |  |  |
| History of violence? |  |  |  |
| Other risks we should be aware of? |  |  |  |

**Send completed form to:**



**Fax- (03) 339 6121 – Tel: (03) 339 6120**

**E:** **arespite2@stepstone.org.nz**