**□ Adult □ Youth**

***Please complete this form and return to Stepping Stone Trust by email:*** mms@stepstone.org.nz ***or fax: 331 6078 or post to: PO Box 33 103, Barrington 8244, Christchurch. Phone MMS on: 331 6076 for more information***

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| Client Name: |  | Date: |  |
| D.O.B: |  | NHI: |  |
| Client Delivery Address: |  |
| No permanent address for delivery yet: |  | Required to go on Waiting List? |  |
| Client Phone: |  | Mobile: |  |
| Client Email: |  |
| Client Ethnicity: |  | Gender: | M / F / Other |
| Next of Kin: |  | Phone: |  |
| Relationship: |  | Mobile: |  |
| Email: |  | Address: |  |
| Case Manager: |  | Phone: |  |
| Mobile: |  | Fax: |  |
| Email: |  | Address: |  |
| Approving Sector: |  | Manager Name: |  |

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| **Please ensure the following are attached:** |  | **Notifications: (SST use)** |
| Crisis Plan: |  |  | Unaunahi □ |
| Treatment Plan: |  |  |
| Last Comprehensive Assessment: |  |  |

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| Client Diagnosis: |  |
| Risk Factors: |  |
| Current Medications: |  |

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| **Other Agencies / individuals working with the client:** |
| Agency Name: |  |
| Worker Name: |  |
| Phone No:  |  |

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| **Other Agencies / individuals working with the client:** |
| Agency Name: |  |
| Worker Name: |  |
| Phone No:  |  |

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| **Other Agencies / individuals working with the client:** |
| Agency Name: |  |
| Worker Name: |  |
| Phone No:  |  |

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| Purpose / Tasks / Goals of engagement of Mobile Medication Service ***(e.g. how non-compliance has affected the client historically and how this service would be of benefit now):*** |  |

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| Estimated time required in the Mobile Medication Service: |
| Short-term: (specify months) |  | Long-term: (1 year +)  |  |

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| **Preferred Time of Delivery:** |
| Morning only | □ | Time: |  | Morning & Evening | □ | Phone call reminders only | □ |
| Evening only | □ | Time: |  | Negotiable | □ | Txt reminders only | □ |

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| **Service Required:** |
| Deliver Medication | □ | Holding own Medication | □ | Observe Taking Medication | □ |

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| **Staff Required:** |
| Clinical Staff required to observe (Registered Nurse/Social Worker) | □ | Experienced staff could observe | □ |

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| **Current Physical Health Issues:** |  |
| **Risk related information for deliveries:** (e.g. requires close monitoring, has a dog, poor lighting at night) |  |
| **Any further information that may assist with how staff need to work with client:** (e.g. current living situation, family, interests) |  |
| **Any specific cultural needs for the client:**(if yes, please provide specific information) |  |
| **Note:** Mobile Medication Service uses **Qualmed Pharmacy** for its clients. Please fax scripts to: **(03) 943 7569** |

**Social Out Come Initiative**

The following information is required by the Department of Health. Please provide the following data:

Question 1: **Accommodation Status** (Options are: Supported, Independent, Homeless)

Question 2: **Employment Status** (Options are: Full Time, Part Time, Not Employed)

Question 3: **In Trainings Status** (Options are: Yes or No)

Question 4: **Wellness Plan** (This is also called a Crisis Plan. Options are: Yes or No)

**Cultural Needs & Medication Allergy Information**

Question 5: Does the client have any Cultural Needs? (Options are Yes or No). If yes, please state need.

Question 6: Does the client have any Medication Allergies? (Options are Yes or No).

 If yes, please state allergy information.

**SST Mobile Medication Service - Conditions of Service**

Rationale: MMS is a finite resource that needs to be available for those in most need. For this to happen we agree to work together with our DHB partners to continually review and evaluate an appropriate fit. This means that MMS at no time can be considered an ongoing “set and forget” service. With this in mind, the following conditions need to be adhered by all referrers to enable MMS to provide a safe, efficient, viable and compliant service. Failure to do so may mean we are unable to accept or continue service.

**Initial Referral**

1. For any new referral please contact the MMS Coordinator and a “current” up to date referral form will be emailed out. The completed referral form can be emailed to mms@stepstone.org.nz or faxed: 03 331 6078.
2. It is suggested that all new referral requests are checked and approved by Sector Managers to consider which of their combined cases have the greatest need for the MMS delivery before sending a referral for service, acknowledging that MMS is a limited resource funded to deliver to 50 clients in total.
3. Referrals will not be accepted without a current crisis plan, photo of client, current signed script for medications and for non Qualmed clients, the associated Douglas Medication Administration Signing Sheets.

**Client Reviews, Medication Allergies, Cultural Sensitivities, Medication Review and Crisis Plans**

1. On a six-monthly basis, MMS will email requesting updates on Client Reviews, Medication Allergies, Cultural Needs, Medication Review Crisis Plans. The referrer or current case manager will be expected to reply to this email request within 10 working days to mms@stepstone.org.nz Information will include:
	1. A review of the client’s service requirements for MMS.
	2. Confirmation of any known medication allergies.
	3. Confirmation of any cultural needs.
	4. Confirmation that the client has had a medication review within the last six months.
	5. A current signed crisis plan with the crisis plan review date within the last six months

**Clients – Who Obtain Medications Through Their Own Pharmacy**

Qualmed pharmacy is contracted to provide the medications for the DHB clients utilizing MMS. Qualmed supply copies of the signed scripts and associated Douglas Medication Administration Signing Sheets to MMS to enable SST to meet the compliance and standards required for M.O.H. and H.P.C.A. requirements. In the cases when Qualmed is not the supplier of the medications, the referrer or case manager is required and agrees to:

1. Take responsibility to monitor and ensure that all current & signed medication scripts and the Douglas Medication Administration Signing Sheets are supplied to MMS before the script commencement date and that the medications are housed in medico blister packs that contain the following information:
2. The name of the client and NHI number.
3. The day of the week (i.e. Monday).
4. Time period to be taken (i.e. mane, nocte).
5. The date.
6. Details of what the medication is, its strength and dose (number of tabs).
7. MMS is able to provide a phone call or text reminder service should the referrer be unable to provide for in point 5.

**Clients – Phone Calls or Text Service Only**

It is agreed between the Referrer and MMS, that this is a reminder service only for the client to take medication. Owing to the nature of this limited service, MMS has no responsibility for the supervision of medication. As the client’s level of wellness and independence dictates, it is acknowledged that the case manager will actively seek to look at other solutions as appropriate to discharge clients from MMS service.

**Clients – Non-Psych Medications**

If the client is obtaining non-psych related medications, the referrer will make it clear which medications MMS are to supervise together with providing MMS with current signed scripts & Douglas Medication Administration Signing Sheets.

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| DHB Referrer: |  | Phone:Mobile: |  | Fax: |  |
| Signed: |  | Date: |  |