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| **PLEASE READ BEFORE COMPLETING THIS FORM**   * Complete this form fully and attach any photographs that will help describe the concerns. * For an ACC assessment, contact your ACC Case Manager for a referral. * For Disability Support Services (DSS) or ACC equipment repairs and maintenance, contact our repairs administrator at [repairs@seatingtogo.co.nz](mailto:repairs@seatingtogo.co.nz) or phone your local Seating To Go base. * If you are self-referring or would like help completing this form, call or email Seating To Go for assistance.   **Send your completed referral to:** | | |
| Waikato DHB region:  BOP DHB region:  Lakes DHB region: | Phone: 07 848 1825  Phone: 07 571 4379  Phone: 07 357 5829 | Email: [hamilton@seatingtogo.co.nz](mailto:hamilton@seatingtogo.co.nz)  Email: [tauranga@seatingtogo.co.nz](mailto:tauranga@seatingtogo.co.nz)  Email: [rotorua@seatingtogo.co.nz](mailto:rotorua@seatingtogo.co.nz) |

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| **1. Client Information** | | | | | | | | | |
| Title: | First Name: | | | | | | Last Name: | | |
| DOB: | | | NHI number: | | | | | Male  Female  Other | |
| Cell phone: | | | Home phone: | | | | | Work phone: | |
| Email: | | | Home address: | | | | | | |
| Living situation | | | On their own | | | | | Supported living | |
| Partner/spouse: | | | Family/whānau: | | | | | Other: | |
| New Zealand Resident: | | Yes  No | | | Client is primary contact: Yes  No | | | | |
| Interpreter needed: | | Yes  No | | | Language: | | | | |
| Ethnicity: | | | | | | | | | |
| NZ Māori | NZ European | | | Asian | | Pacific Islander | | | Other: |
| Alternative contact details for appointments: | | | | | | | | | |
| Full Name: | | | | | Relationship to client: | | | | |
| Email: | | | | | Contact phone: | | | | |
| Additional information you think we should be aware of (e.g. risks, hazards, alerts): | | | | | | | | | |
| Describe: | | | | | | | | | |

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| **2. Health & Disability Background** | | | |
| Medical History: (primary and secondary diagnosis, including medical and surgical) | | | |
| Diagnosis/Condition: | | Date of onset (if known): | |
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| Attach specialist report if available e.g. orthopaedic, neurologist, paediatrician, hospital discharge summary | | | |
| Describe the ability to get around the home and community, participate in activities / education /work, communicate, and be safe: (Include access to home, school & work if applicable) | | | |
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| Key Therapists / Professionals / Agencies involved: | | | |
| (Please include health professionals, MOE, Rest Home, Community Agencies, field workers etc. as applicable) | | | |
| Name: | Role: | Phone Number: | Email: |
|  | Doctor (GP) |  |  |
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| **3. Reason for Referral** | |
| (Describe in detail to assist with prioritisation. Include indicators for Level 2 assessment): | |
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| Meets Level 2 need for wheelchair & seating needs (refer to links below): Yes  No  Not sure | |
| [Click here for Level 1 Clinical Indicators](https://www.enable.co.nz/media/documents/indicators-for-wheeled-mobility-and-postural-management-level-1-june-2014-1.pdf) | [Click here for Level 2 Clinical Indicators](https://www.enable.co.nz/media/documents/wmpm-level-2-clinical-indicators.pdf) |

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| **4. Specific Concerns for the Client:** | |
| Risk of injury or loss of independence with mobility, transferring, eating etc. | |
| Describe (including current ability & risks): | |
| Experiencing falls, or falling while trying to use their wheelchair | |
| Describe: | |
| Rapid deterioration – loss of function within the last 3 months resulting in increased carer assistance | |
| Describe: | |
| There has been a change in sitting ability and comfort/tolerance | |
| Describe: | |
| Presence of open pressure injury or imminent skin breakdown | |
| Affected area/s? | How long since it started? |
| Describe (include how this is being managed): | |
| Risk of respiratory, aspiration, digestion/elimination problems related to their seated position | |
| Describe (include how this is being managed): | |
| Transitioning to wheeled mobility (under five years old) | |
| Describe: | |
| Carer injury or risk of carer injury | |
| Describe: | |
| Post orthopaedic surgery (e.g. hips or spinal rodding), upcoming surgery, or hospital discharge | |
| Describe and attach relevant documentation if available: | |

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| **5. Equipment** | | |
| Describe current Wheelchair & Seating equipment and accessories: | | |
| Equipment | Details | Funding |
| (manual, power, transit, self-propel, buggy, seating, accessories, other) | (Company, make, size) | (DSS (Enable), ACC (Accessable), Private) |
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| **6. Residential Care** |
| Is the client over 65 years of age and residing in a Rest Home / Hospital? |
| Yes – please continue filling out the form |
| No – skip to declaration (section 7) |

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| **THE FOLLOWING DSS ELIGIBILITY INFORMATION RELATES TO PEOPLE WHO RESIDE IN RESIDENTIAL CARE:**   * The wheelchair is needed to support a person’s all-day functional mobility. It is individualised or customised for their sole use and not suitable for the general mobility needs of other residents within the facility. * The customised or individualised seating (cushion or backrest) on a wheeled mobility base is necessary because: * There is no suitable seating or chair in the facility to meet the person’s identified disability related needs and * The person has an essential need for, and ability to benefit from, individualised or customised seating, and * The impact of the seating not being provided influences the way the person will manage daily living activities, their safety and an impact on carers (including to reduce the need for a higher level of care).   Note:   * Sole use means the equipment has been provided for the person for their individual use only. The equipment is over and above what a residential care provider would be expected to provide and is not for communal use. * Wheeled mobility is unable to be provided for transit in around the facility such as to and from dining room, gardens etc. |

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| Independent Mobility |
| Does the client have potential to be independently mobile in and around the facility? Yes  No  Not sure |
| Possible option (if known):  Self-propelling wheelchair  Punting with feet  Power wheelchair |
| If a power wheelchair is proposed following a successful trial & training, are residents able to utilise power mobility within the facility? Yes  No |
| Alternatives considered where proposed long-term solution will be a transit (carer assisted) wheelchair: |
| Outline the static seating solutions available (lazy boy, care chair etc.) in the residential facility: |
| Describe: |
| Indicate why these solutions cannot be utilised to provide the person with a safe seated position for meals, communication and social interaction: |
| Describe: |
| Outline the wheelchair options available in the residential facility: |
| Describe: |
| Indicate why these wheelchairs (self-propelling or transit wheelchair) cannot be utilised to provide the person with safe mobility in and around the facility e.g. from room to lounge: |
| Describe: |

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| **7. Declaration** | | | | |
|  | This is a self-referral. I confirm that the information outlined in this referral is true and accurate. I am aware that this information may be shared with other health professionals. |  |  |  |
| Signed: |
| Name: |  |  |
| Designation: |  |  |
|  | This referral was completed truthfully on behalf of the above person. Consent has been given by them or their parent/guardian for this referral. They are aware that this information may be shared with other health professionals. | Date: |  |  |
| Phone: |  |  |
| Mobile: |  |  |
| Email: |  |  |
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| Note: If you have photos that could support this referral, please insert them on the following page or attach them during submission. For examples of useful images, follow this link: [Guidelines for photos and measurements](https://www.seatingtogo.co.nz/assets/Guidelines-for-photos-and-measurements.pdf) |

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| Client Name: |  |  |

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| Caption: | Caption: |

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| Caption: | Caption: |