

Fill in only if patient label is unavailable

Name: DoB:

NHI: Phone:

Address:

**SPRINGHILL REFERRAL CHECKLIST**

# SPRINGHILL REFERRAL CHECKLIST

Client Name:

Referrer Name:

Referrer Phone:

The following items are essential:

Completed Springhill referral form

Comprehensive assessment – including goals for treatment and risk assessment

Signed Springhill Residential Agreement

Early exit plan – pre-& post discharge supports

Smoke free screening – support and interventions provided

Ensure the client is aware that Hawke’s Bay DHB is a teaching DHB and students may be attending the Centre.

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Referrer must be in contact with client two weeks prior to entry

Pre-admission phone call to client

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Additional information may be requested:

Special needs / requirements / mobility / diet / physical health issues

Childcare issues / family / dependents

Blood test results – please send results **if** you have had tests done

Psychiatric formulation / consultant letter

Detox Plan

Clarification of any legal issues

Eating Disorders

Comments:

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| *Office use only*      Referral Received: Region: Central / Midland |