

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 |