NORTHLAND PRIMARY HEALTH ORGANISATIONS

Primary Options Programme Northland (POPN)
Hospital Referral Form

For patients residing in the Northland district only

Attach hospital sticker with patient details here			Date: Time:
Hospital contact person:	**Hospital phone no:** **Hospital fax no:**		**Location (e.g. Ward no.):**
Ethnicity:	**Date of planned discharge:**		**Lives alone?** **Yes / No (please circle)**
Diagnosis and relevant medical history:		**Date of admission:**	
Next of kin:	**Relationship to patient:**	**NOK phone no:**	

By referring this patient you confirm the following:

- This patient can be managed safely in the community with Primary Options funding and would otherwise be admitted or kept in hospital.
- A discharge summary which includes a summary of current medications has been completed. One copy is to be faxed to the POPN coordinator (09 4383210) and an additional copy faxed to the patient's GP prior to discharge.
- This condition is not funded by another funding stream (ie. ACC, maternity)
- Residential care is required for a maximum of 3 days

Level of care required (please tick):

	Patient is mobile		Mobile with walker/stick		Patient is immobile
	Patient is independent		Requires some supervision		Patient requires assistance
	No signs of dementia		Dementia patient (secure unit required)		Urinary & faecal incontinence
	Delerium				

The patient is known to NASC? Yes / No	**Referral has been made for ongoing care to: NASC / District nursing**	
Patient plan following treatment through Primary Options:		
GP Name:	**NZMC Number:**	**GP Phone:**

Services required (please circle):

Dr follow-up appointment	Referral to A&M	3 nights rest home
Dr home visit	Taxi	Meals on wheels
IV therapy	Ambulance	Equipment hire _______________
Ultrasound________________________	Family will transport	Home help

Assessment notes are available from (please circle):

OT PHYSIO SOCIAL WORKER POPS NASC

Patient informed consent: X____

Name: ___________________________________ **Relationship to patient (if signed on behalf):**____________________

I have been informed and understand the choices available with regards to my healthcare. I understand the information on this form relating to this illness will be made available to Primary Options Programme Northland and sub-contracted healthcare providers. **I UNDERSTAND THAT THIS IS FUNDED FOR A MAXIMUM OF THREE DAYS ONLY - ANY COSTS BEYOND THE THREE DAYS WILL NOT BE FUNDED BY THE PRIMARY OPTIONS PROGRAMME NORTHLAND.**

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