

Request to MIRAMARE for a Support Needs Assessment

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|------------------------------|------------------|
| Who makes the request. Name: | |
| Workplace | Date of Referral |
| Address | Phone(s) |
| Email | @ |

Do you have client authority to provide information. Yes (required)

Client

| | |
|------------------|----------------|
| Surname | First name |
| Other name | Date of Birth |
| NHI Number | Male or Female |
| Title | Ethnic Group |
| Postal Address | |
| Physical Address | |
| Phone (s) | |
| Email | @ |

Is there a parent or caregiver we should contact first.

| | |
|---------|--------------|
| Name | Relationship |
| Address | Phone(s) |
| Email | @ |

Reason for referral and why are support services required.

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What is the current living situation of the client.

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We seek the following documents from this person's clinical file

- a) A copy of the most recent treatment plan/review (which will include legal status, diagnosis, consideration of risk and clinicians involved).
- b) Early warning signs / Relapse prevention plan.

We understand that it is the policy of the Southern DHB Provider Arm Mental Health Service that these will already exist for all clients in its service. If the client is not attached to the Southern DHB Mental Health service, similar information is sought.

Please answer the information below if it is not already contained in attached documents.

| | | | | |
|---|-----|--------------------------|----|-------------------------------------|
| What is the diagnosis? | | | | |
| Please detail by whom | | | | |
| Please detail when last diagnosed and review time | | | | |
| Is appropriate treatment in place? | | | | |
| What is the treatment ? | | | | |
| Please identify the clinical key worker | | | | |
| Is the key worker ongoing ? | | | | |
| Are there risks of harm to self or others ? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> (required) |
| If yes to risks please describe. | | | | |
| Is the client on the risk management register of the Southern DHB | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> (required) |

Feel free to use separate sheets.

Other reports and correspondence can be useful to us.

DHB Clinical file Information is attached Yes

Other information is attached. Yes

Please list. _____

If this request is accepted we will undertake a Needs Assessment Report. Following that we can make decisions about allocation of ongoing support services.

MIRAMARE
NEEDS ASSESSMENT &
SERVICE CO-ORDINATION

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