

Request to Synergy Wellness for a Support Needs Assessment

Who makes the request

Name	
Workplace	Date of Referral
Address	Phone(s)
Email	@

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

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

What is the current living situation of the client?

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 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 (required)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes to risks please describe.	
Is the client on the risk management register of Healthcare Otago (required)	Yes <input type="checkbox"/> No <input type="checkbox"/>

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.



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