



*Equip is contracted to the Ministry of Health to provide home-based recovery support on the North Shore to people experiencing Major Mental Disorders*

**Referral for Entry into Adult Flexible Community Support Service**

**DO NOT FAX THIS INFORMATION**

*The information contained in this form is Private & Confidential. It remains the property of Equip and is subject to the Conditions of the Privacy Act 1993.*

**Please forward completed forms to:**

**Front Desk Administrator  
Equip  
PO Box 65 385  
Mairangi Bay  
Auckland 1310  
Ph 477 0338**

**Please direct all enquiries to:**

**CSW Team Leader  
Equip  
Ph: 477 0338**

**CONFIDENTIAL**



## Service user information

- ✓ **Please keep this information for your own future reference.**

**Equip** Community Support service provides support for an hour a week for service users experiencing mental illness in on the North Shore. Equip is a recovery-focused service. Close liaisons with clinical and community services are maintained to access the resources that individuals need to be able to make the choices they want.

We seek to provide active rehabilitation programmes for all of our service users, by working with individuals and the support people of their choice (family/friends) to develop and deliver plans that focus on long term goals for the future. We understand the importance of involving informal support people in long term recovery and aim to help the family or friends of the service user to understand the impact of mental illness and ways in which to manage the effects of mental illness. We appreciate if you bring a supportive family member or friend to the meetings.

### **Some helpful contact details:**

#### □ **Client Advisor:**

**Equip** recognises the importance of service users having input into the way services are delivered.

To help these things happen Equip employs a client adviser who will from time to time be asking for input and feedback from service users within our service.

Our current client advisor is Vaoesea Ioasa. She can be contacted through the Equip office on 09 477 0338, or via post at P.O. Box 65 385, Mairangi Bay.

#### □ **Family Advisor:**

**Equip** also recognises the importance of families and significant others having input into the way services are delivered.

To help these things happen Equip employs a family adviser who will from time to time be asking for input and feedback from families and significant others within our service.

Our current family advisor is Rochelle Binnie. She can be contacted through the Equip office on 09 477 0338, or via post at P.O. Box 65 385, Mairangi Bay.

### **Referrals are eligible for Equip's Community Support Work service if:**

- The individual being referred is at least 18 years old and experiences a mental illness (Axis I diagnosis as diagnosed by a GP or psychiatrist), and
- The individual is living within or has a desire to find accommodation within Equip's geographically assigned area, and
- The service user signs the Declaration Form stating they have read, understood and accept the following information provided for them to keep:
  - Conditions for Support
  - Equip Policy Concerning the Collection and Disclosure of Health Related Information
  - Service user Informed Consent to Exchange of Health Information.

## **Conditions for support**

- ❑ You understand that we will be actively working with you and your informal supporters towards achieving your social, interpersonal and work related goals during your time with Equip. Where you do not have family/ friends or others to support you, we will work with you to find some support in this area.
- ❑ You understand that in order for us to assist you to achieve your plans for the future we will need to complete assessments to find out what you want to be doing, how you are progressing with this, and what barriers you may be encountering.
- ❑ You understand that Equip staff will be communicating with your responsible clinician.

## **Equip Policy Concerning the Collection and Disclosure of Health Related Information**

[A complete copy of Equip's Privacy Policy is available on request]

In order to fulfil our role as a mental health rehabilitation service, Equip staff regularly gather health information relating to our service users. Some means of doing this are:

- ❑ Referral forms
- ❑ File notes
- ❑ Verbal information
- ❑ Formal assessments, including a *CPS-50* interview, a *Community Health Record* or a *Buckingham Side Effects Rating Scale*
- ❑ Other written documents such as goal setting records, thought records or problem solving sheets.

The *Health Information Privacy Code 1994* allows Equip to disclose such information to other agencies or people involved in the treatment and support of our service users. Generally this means that service users' health information may be shared with and/or collected from:

- ❑ Family members, where such people are identified as having a role in supporting service users.
- ❑ Staff from Waitemata District Health Board mental health services
- ❑ Psychologists or other therapists who have been engaged to provide specific therapy for individual service users
- ❑ GP's or other agencies that provide specific medical services for service users
- ❑ Other agencies or individuals that provide specific support for service users to enable them to meet their identified goals. Three common examples are: employment support agencies, budgeting agencies and landlords.

Three other important factors concerning the disclosure of health information are:

- ❑ Equip will only share information that is directly relevant to the situation involving other agencies or people
- ❑ Equip may choose to withhold information if it is perceived that to release it would not be in the best interests of our service user and/or the service user requests that we do not do so, and we are not legally obliged to do so
- ❑ Equip may release information without a service user's consent if:
  - it is disclosed for the purpose for which it was collected
  - disclosure will lessen or prevent a serious and imminent threat to public health, or public safety, or the life or health of the service user or any other individual

**Equip acknowledges the right of its service users to:**

- Know that we hold personal health information concerning them
- Have access to that information on request, except in situations where exemptions under the Privacy Act 1993 may be granted
- Request correction of any information concerning them. If this is denied they are entitled to have attached to the information a statement of the correction sought but not made.

**Service user Informed Consent to Exchange of Health Information**

**I give consent for:**

- Staff at Equip to collect and record any of my health related information which they consider necessary
- Staff at Equip to contact my informal support person (as designated) if required.
- My nurse/psychiatrist/GP contacting my support worker at Equip to inform them if my medication changes.

**This consent is given on the condition that:**

- Staff of such organisations will inform me if any discussion has taken place, and will clearly explain why the discussion was necessary, and what was discussed, outside of normal dialogue.
- All information obtained will remain confidential, and not be given to any person outside the above organisations without my prior written consent; except in situations allowed for under the Privacy Act 1993, the Health and Disabilities Act 1993, and other legislation which allows certain Government Departments to request and be given specific information. Should such a situation arise, Equip shall inform me of such request and supply details of what information has been given, even though my consent to such provision is not required.

**Further, I understand that:**

- Equip, in acknowledging the requirements of the Privacy Act 1993, undertakes to:
  - Keep me informed of what information is held about me, and the reason for holding it
  - Keep all information locked away, accessible only to those involved in my support
  - Allow me access to that information in accordance with Equip's procedures
  - Add my comments to my file, if I disagree with anything written on it
- The Ministry of Health requires Equip to supply non-identifying information to help with measuring the quality of the Support Service.
- This consent will become invalid six (6) months after I leave Equip in accordance with Ministry of Health contracting requirements.



## Declaration Form

✓ **Please return completed Declaration Form to Equip**

I have read, understood and accept the Conditions for Support, Equip Policy Concerning the Collection and Disclosure of Health Related Information, and the Service user Informed Consent to Exchange of Health Information which were provided for me to keep.

I give permission for Staff at Equip, and my responsible clinician to be able to confer regularly in order to provide me with the best support and most effective service.

In addition, I give permission for Staff at Equip to communicate with other people who are involved in providing me with support. See below for which type of information can be shared with which designated person or agency so please write the numbers into the table.

Type of information to be exchanged:

- |  |   |
|--|---|
| 1. My assessment data, goal plans            | 3. Data about my progress                           |
| 2. Things I find helpful when I am in crisis | 4. When I am getting unwell, my early warning signs |

<b>Agency.</b> Please write in name.	<b>Information to be exchanged</b> (eg. 1 - 4)	<b>Comments</b>	<b>Service user Signature</b>
Family/Whanau			
Landlord			
Budget Service			
Other			
Other			

Service user's name (please print).....

Service user's signature ..... Date .....

Witness's signature ..... Date .....

Occupation .....



**Referrer Form**

✓ **When completed send to:** Front Desk Administrator  
 Equip  
 PO Box 65.385  
 Mairangi Bay, Auckland

Please ensure that the Service user and the Referrer Form are both completed, *then send both forms, along with the declaration pack* to Equip. Referrals are only valid if all three forms are received.

**A. GENERAL INFORMATION**

Service user name .....

Current address .....

.....

Home phone no ..... Mobile phone no .....

Email address ..... Other contact phone no .....

Age ..... Date of birth ..... Male/Female

**N.H.I. Number** .....

**B. REASON FOR REFERRAL**

How do you think our service would help your service user?

.....

Referrer's name ..... Position (eg PDN/OT/SW/GP).....

Contact postal address .....

.....

Preferred form of contact: Email .....

Phone no .....

Fax .....

**C. FAMILY BACKGROUND**

Service user's Next of kin .....Relationship (mother, brother, etc).....

Their address and phone number .....

Cultural identity (include tribal affiliation if applicable) .....

**D. SUPPORTS**

Who are the people your service user gets most support from? .....

.....

What areas does your service user need more support in? .....

.....

**E. MENTAL HEALTH**

Service user's psychiatrist .....CMHC .....

Community Mental Health Keyworker.....

Other interventions/treatment .....

Axis 1 Diagnosis .....

Secondary Diagnosis (where applicable) .....

Age of Onset .....

Number of psychiatric hospital admissions in past 12 months .....

Total duration of Inpatient Care (approximately in weeks) .....

Number of days respite in past 12 months .....

Where are their medical records currently held? .....

How strongly does the service user agree or disagree with their diagnosis? Please comment

.....

.....

Medication (Please add quantities as well)

<u>Medication</u>	<u>Dosage</u>
.....	.....
.....	.....
.....	.....
.....	.....

Any side effects or other issues with medication? Please comment

.....

.....

Does the service user struggle to take medication as prescribed? Yes / No

**F. SPECIAL NEEDS**

Please state which (if any) of the following have been or are issues / risks for your service user -

- Physical harming self Past / Present
- Physical harming others Past / Present
- Another person harming / abusing them Past / Present
- Other ..... Past / Present

**Substance Use**

- Alcohol Yes / No Past / Present
- Drugs Yes / No Past / Present
- Solvents Yes / No Past / Present
- Other (please specify) ..... Past / Present

Do you think that substance use is affecting your service user's ability to manage their day-to-day living now? Yes / No

**Legal Involvement**

Is your service user currently involved with the Police/Courts? Yes / No

If yes, please explain .....

.....

Have they had previous involvement with the Police/Courts? Yes / No

If yes, please explain .....

.....

**G. CURRENT LEGAL STATUS**

Are they currently under the -

Mental Health Act	Yes / No
Criminal Justice Act	Yes / No
PPPR Act	Yes / No
Other (eg Probation, Domestic Protection Order)	Yes / No

**H. OTHER ISSUES**

**What else do we need to know?**

Please note any other historical/risk/safety events or issues that may be relevant .....

.....

If possible please attach

- Early Warning Signs
- Risk Management Plan (if relevant)
- Service user Summary (if available)

Referrer's Signature .....

Date .....



## Service user Form

My name is ..... Date .....

### A. SPECIAL NEEDS

1. Which of the following have been or are **issues/risks** for you at the moment?

- |                                     |                |
|-------------------------------------|----------------|
| • Physically harming self           | Past / Present |
| • Physically harming others         | Past / Present |
| • Another person harming/abusing me | Past / Present |
| • Other .....                       | Past / Present |

2. **Religious beliefs or affiliations** (Optional) .....

Would you like the Community Chaplain to contact you? .....

3. **Substance use** Have you ever used:

- |                                |          |                |
|--------------------------------|----------|----------------|
| • Alcohol                      | Yes / No | Past / Present |
| • Drugs                        | Yes / No | Past / Present |
| • Solvents                     | Yes / No | Past / Present |
| • Other (please specify) ..... |          | Past / Present |

Do you think that this substance use is affecting your ability to manage your daily living now?  
Yes / No

### 4. Legal Involvement

Are you currently involved with the Police/Courts? Yes / No

If yes, please explain .....

.....

Have you had previous involvement with the Police/Courts? Yes / No

If yes, please explain .....

.....

### Current Legal Status

Are you currently under the -

- |   |          |
|---|----------|
| Mental Health Act                               | Yes / No |
| Criminal Justice Act                            | Yes / No |
| P.P.P.R. Act                                    | Yes / No |
| Other (eg Probation, Domestic Protection Order) | Yes / No |

**B. SUPPORTS**

- Who are the people you get the most support from?  
(eg family/whanau; friend; agencies/caregivers; doctor; psychologist; Community Mental Health Keyworker, or other)

.....  
 .....

Please note the details of the person(s) you would like us to involve as informal support for you (may be a family member, a friend, or someone else

Their contact details: Name: .....

Phone: .....

Home address: .....

Please tick the areas that you would like more support in:

- making friends
- improving existing relationships
- getting work
- finding accommodation
- getting back into a sport or activity
- other (please specify)

**C. GENERAL HEALTH CONCERNS**

I am allergic to the following drugs/food .....

I have these conditions/disabilities .....

My G.P. is ..... Phone No .....

Their address is .....

.....

**D. FINANCES**

I manage my own finances Yes / No

If no, who helps you with this? ..... Phone.....

My Benefit type is .....

My WINZ office is .....