Complete this form to describe a patient’s injury (as well as any other conditions they have) and the support they require from ACC for a safe discharge. Return this form **at least 48 hours before the planned discharge date**.

When you’ve finished, return this form to [claimsdocs@acc.co.nz](mailto:claimsdocs@acc.co.nz).

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| --- | --- | --- |
| 1. Referral information | | |
| Date: | Planned discharge date: | Supports required on: |

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| --- | --- | --- | --- | --- | --- |
| 2a. Service request (tick all that apply) | | | | | |
| Home & Community Support (HCS) | Interim Care (eg ARC) | | Equipment | | Rehabilitation |
| Request ACC to consider HCS  Notify ACC HCS – Return to Independence (referral send to providers) | Request purchase order approval | | Notify ACC of equipment provided | | Request rehabilitation services  Notify rehabilitation services have been put in place |
| 2b. Evidence to support referral | | | | | |
| ACC45 | | Copy of Allied Health needs assessment report | | Discharge report | |
| Rehabilitation plan | | Emergency department discharge notes | | Nursing summary | |
| InterRAI Assessment | | ACC4249 | | NASC assessment | |

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| 3a. Client details | |
| If completing this form manually, attach BRADMAR sticker over the top of relevant details | |
| Client name: | Date of birth: |
| Address: | |
| Contact number: | NHI number: |
| Occupation: | |
| 3b. Authorised alternative contact details: | |
| Contact name: | Contact number: |
| Relationship to client: | |

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| 4. Injury details | |
| ACC45 number: | Date of injury: |
| Injury diagnosis at the time of discharge: | |
| How did the accident happen? | |
| Relevant post injury inpatient history (including surgery): | |

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| 5. Medical or disability details | |
| Does the client have any existing conditions that might affect their ability to rehabilitate?  No  Yes; select all that apply in the boxes below: | |
| Hypertension or  Hypotension | Cognitive impairment |
| Osteoporosis | Hearing impairment |
| Arthritis | Visual impairment |
| Total hip joint replacement:  Left  Right | Total knee joint replacement:  Left  Right |
| Mental health diagnosis | Chronic obstructive pulmonary disorder (COPD) |
| Heart disease | Diabetes (NIDDM/ID) |
| Neurological condition, please specify: | Other, please specify: |

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| 6. Functional limitations | | | |
| Select client’s functional limitations due to personal injury: | | | |
| Weight bearing status | Mobility aids | Transfers | Upper limb |
| Full weight bearing  Weight bearing as tolerated  Non-weight bearing  Partial weight bearing  Abide by hip precautions | Nil aid  Walking stick  Crutches  Standing walking frame  2W2C frame  Pram handle frame  Gutter frame  Wheelchair | Independent  Supervision  1 person assist for transfers  2 person assist for transfers  Hoist transfers  Other, specify details: | Upper limb limitations:  Left  Right.  Dominant hand:  Left  Right |
| Other, please be clear on limitations that exist due to personal injury: | | | |
| What was the client’s mobility pre-injury:  Full mobility  Limited mobility, please specify: | | | |

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| 7. Discharge planning (attach the discharge summary report if available) | |
| Client is discharging from:  Acute inpatient  Non-acute rehab inpatient | |
| Will the client be discharged to the same address as stated in section 3a?  Yes  No, discharge address:  Contact phone: | |
| Does the client live alone:  Yes  Other, please specify living situation: | |
| Does the client require interim care: Yes No  If yes, complete section 12, as well as all other relevant sections. | |
| Does the client, or anyone else in the household, receive formal support:  No, continue on to section 8  Yes, complete the following: | |
| Carer/agency: | Hours: per  day  week  fortnight |
| Home visit completed: Yes No | Does the client require an interpreter:  Yes, specify language:  No |
| List any informal support available in the home or community to assist the client, eg family/whānau, neighbours, church, friends, social clubs: | |

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| 8. Equipment | |
| Will the client be provided equipment on discharge: Yes, complete the table below No | |
| Equipment provided, include make and model if known: | How long will the client require the equipment: |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| If the equipment will be needed for longer than 6 weeks post-acute discharge, complete a short-term equipment request form (ACC4249). | |

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| 9. Rehabilitation services |
| Complete this section if the client requires ongoing rehabilitation |
| Rehabilitation required: |
| Will this rehabilitation be put in place by the discharging hospital:  Yes  No |
| If yes, list any rehabilitation services the discharging hospital will be providing on discharge that you don’t need ACC to put in place: |

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| 10. Support requirements due to injury | | |
| Complete this section if you haven’t attached to a Nursing Treatment or Allied Health support assessment. | | |
| Did the client have any publicly or self-funded care prior to injury:  Yes; specify details below  No | | |
| Support | Pre-Injury | Post discharge needs (excluding client support network) |
| Household tasks (eg laundry) | Independent  Assistance needed |  |
| Showering/ bathing | Independent  Assistance needed |  |
| Toileting | Independent  Assistance needed |  |
| Meal preparation | Independent  Assistance needed |  |
| Transport | Independent  Assistance needed |  |
| Medication management | Independent  Assistance needed |  |
| Childcare |  |  |
| Other, please specify: |  |  |
| List any risks or hazards a provider needs to know when visiting the client’s home, eg dogs, firearms, infectious diseases: | | |

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| 11. Home and Community Supports, if required | |
| Determine which HCS service is appropriate using the flow chart below. | |
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| Select an outcome:  Refer for HCS - Return to Independence (select a supplier below and complete remainder of form)  Notify ACC to consider supports (complete the remainder of the form as needed and send to ACC) | |
| HCS – Return to Independence suppliers (national coverage) | |
| Ask the client if they have a preferred supplier, if yes – refer client to their preferred supplier.  Many of these suppliers work with a network of subcontractors. If a client is already receiving care from a supplier that is not listed below, call the supplier and confirm they are an ACC subcontractor.  If the supplier is not an ACC subcontractor, select a supplier from the list below and email this form directly to them. | |
| Care on Call (NZ) (Florence Nightingale) | Solora Healthcare and Rehabilitation |
| Oko Āio Limited | Te Amo Atawhai |
| Access Community Health | Healthcare New Zealand |
| Health Vision | Custom Care Nursing Limited |
| Geneva Health | See section 15 for Supplier contact details |
| Has a telephone referral been accepted by the HCSRTI supplier?  Yes  No | |

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| 12. Interim care requirements | |
| Complete this section if the client requires funded interim care due to their injury. | |
| What is the clinical rationale for the client needing interim care? Why can’t the client go home with a support in place: | |
| Name of residential facility the client is being discharged to: | Date interim care is required from: |
| We are required to raise a purchase order for the entire period of the client’s stay in interim care. Let us know the anticipated length of stay (usually up to 6 weeks from discharge date): | |
| Daily rate, if known: | |
| **ACC internal use:** Contact the residential facility and confirm the daily rate. Create a purchase order for the residential facility (or Te Whatu Ora if requested) using the RRINT code, when criteria is met. | |

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| 13. Hospital contact details and declaration | |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete.  Provide the best contact for ACC to contact with regards to the client. | |
| Contact Name: | Phone: |
| Hospital and ward: | Email: |
| Signature:  Electronic documents will be deemed as signed by the person named. | Date: |

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| 14. Client declaration | |
| I confirm that to the best of my knowledge, all the information I have provided on this form is true and correct. I authorise ACC to collect relevant medical and other records to help them make decisions about my claim. | |
| Name: | Name of representative, if signing on client’s behalf: |
| Signature:  Electronic documents will be deemed as signed by the person named. | Date: |

In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.

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| 15. Supplier contact details | | | |
| Supplier | Phone | Fax | Email |
| Care on Call (NZ)  (Florence Nightingale) | 0800 633 822 | 09 940 9102 | referral@careoncall.co.nz |
| Solora Healthcare and Rehabilitation | 0800 725 705 | 0800 001 636 | homecare@solora.nz |
| Oko Āio Limited | 0800 656 246 | 07 595 0248 | referrals@okoaio.nz |
| Te Amo Atawhai | 0800 183 266 | **06 835 3945** | referrals@teamoatawhai.co.nz |
| Access Community Health | 0508 123 010 | 0508 123 011 | acc\_referrals@access.org.nz |
| Healthcare New Zealand | 0800 002 722 ext. 3 |  | referral@healthcarenz.co.nz |
| Health Vision | 0508 733 377 | 0508 733 378 | service@healthvision.co.nz |
| Custom Care Nursing Limited | 0508 687737 | 06 929 9821 | referrals@customcarenursing.co.nzReferrals@customcarenursing.co.nz |
| Geneva Health | 0800 436 382 |  | homecareemails@genevahealth.com |