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| Enable_RGB | **ENAO802** | **POSITIONING OUTREACH SERVICE****outreach@enable.co.nz 0800 362 253** |
| **REFERRAL FOR AN APPOINTMENT** |
| Date of Referral |    /    /      | Preferred Time |       |
| Date of Next Clinic |    /    /      | Impossible Times |       |
| Address for Clinic Appointment:       |
| Client meets MOH eligibility criteria: yes **[ ]**  no **[ ]**  |
| **CLIENT DETAILS** | **EMS ASSESSOR DETAILS** |
| NHI |       | Name |       |
| Name |       | AEA No: |       |
| Date of Birth |   /  /     | Email Address |       |
| Telephone |       | Telephone | (     )       |
| Gender | **[ ]**  Male **[ ]**  Female | Mobile  | (     )       |
| Ethnicity |       | WMPML1 **[ ]**  WMPML2 **[ ]**  WMPM Custom **[ ]**  WMPM Lying **[ ]**  |
| Diagnosis |       |  |

Please provide information on the following –

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| **CONTEXT –** description of the social and environmental situation. Please include information such as where the person lives, where the person works / attends school or daycare, relevant caregiver input, and any environmental challenges.  |
|       |
| ***The equipment is essential for:***  | **Resides**  |
| [ ]  Mobility in the home | [ ]  Remaining in the home  | [ ]  Own home |
| [ ]  Fulltime Education | *[ ]*  Main Carer  | [ ]  Residential Care Over 65 |
| [ ]  Fulltime Employment  | [ ]  Vocational Training  | [ ]  Residential Care Under 65 |
| [ ]  Communication  | [ ]  Voluntary Work  | [ ]  Lives Alone |
| **FUNCTIONAL LIMITATIONS –** description of the relevant disability and limitations experienced by the person. Please include information such as how the person currently mobilises, how they transfer in/out of their chair, any specific challenges faced by the person. |
|       |
| **ASSESSMENT FINDINGS** |
| Type of Bed |       |
| Size of Bed  |       |
| If bed is specialised, detail functions |       |
| Type of Mattress |       |

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| **What is the client’s preferred sleep position** (describe posture/positioning) |
|       |
| **Is the client able to lie in Supine, Side Lying, and/or Prone** (describe posture/positioning) |
|       |
| **How often does the client wake during the night** (how often is the client being attended to by carers) |
|       |
| **Does the client need to be turned during the night** (who is turning the client and how frequently) |
|       |
| Does the client have a latex allergy? yes [ ]  no [ ]  |
| Chailey Level  |       | GMFCS Level  |       |
| **How is the client transferred in/out of bed** |
|       |
| **Goals of postural management** (please indicate if goals relate to supine, side lying or prone) |
|       |
| Additional Assessment Information:       |
| Please paste any photos into this section:    |