|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Enable_RGB | | | **ENAO802** | **POSITIONING OUTREACH SERVICE**  **outreach@enable.co.nz 0800 171 995** | | | |
| **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 –

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | | | |