Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Disability Support Link
He Ara Whakamana
mo te hunga hauā

Application for authorisation for:

1. End-of-life residential care and support in an aged care facility for a maximum of six weeks (COPL0005; COPL0006); ***or***
2. Additional end-of-life Carer Support days in the community for a maximum of six weeks

Important notes:

- The person completing this clinical recommendation must be a qualified health professional. If you are not a doctor, a doctor must complete the 'declaration' over page that the client is considered to be in the terminal phase and **not expected to live beyond six weeks**.
- It is the responsibility of the person making the recommendation to ensure the client and their family has been advised that if the recommendation is accepted, that the funding stream will change at six weeks if the client's condition improves, as new funding criteria will apply.
- The information on this form will be used to make decisions on service allocations for residential care or carer support to support end-of-life and will be retained by Disability Support Link (DSL).
- Incomplete application forms may result in a delay in making a decision.
- Telephone enquiries should be directed to DSL 07 839 8883 or 0800 55 33 99.
- Fax completed application form to DSL 07 839 1225 ***or*** email to dsloffice@waikatodhb.health.nz.

Application for *(tick one)*	☐ Carer support days	☐ Hospital level COPL0006	☐ Rest Home level care COPL0005

Client details	
Surname:	NHI number:
First name:	DOB:
Address:	Phone:
Has client consent for this application been obtained?	☐ Yes ☐ No

Client's preferred contact person		
Name:		
Address:		
Phone - Home:	Work:	Mobile:
Relationship to the client:		

Clinical recommendation
Diagnosis Prognosis
Additional support recommended: If the application is for residential care: Which facility has the client chosen?
Is the client eligible for hospice-funded end-of-life care in the hospice facility?

Client name _____ NHI _____

Senses and communication

Please circle on the chart below your assessed PPS level under each heading for this client

PPS Level	Ambulation	Activity and evidence of disease	Self-care	Intake	Conscious Level
100%	Full	Normal activity and work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity and work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40%	Mainly in bed	Unable to do any activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- Confusion
30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- Confusion
20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- Confusion
10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma +/- Confusion
0%	Death	–	–	–	–

Palliative Performance Scale (PPSv2) Version 2, Victoria Hospice Society, Australia

What specific registered nurse care is required for this client?

Details of person completing this application

Name (please print clearly):	
Signature:	
Position:	Service/department/organisation:
Contact phone number:	Fax number/email:

☐ I have advised the client/family that if the client's condition changes to prolong life past six weeks new funding criteria will apply and this will mean the payment for care costs becomes the responsibility of the client.

☐ In the event that you can't be contacted about this application who else can we contact?

Name: Phone number:

Declaration

☐ I am a medical practitioner and I have assessed the client as being in the terminal phase and not expected to live beyond six weeks.

Name:	Signature:	Medical Council number:

Please do not attach any clinical notes/documents to this form

FAX COMPLETED FORM TO DSL 07 839 1225 or EMAIL dsloffice@waikatodhb.health.nz

Incomplete information may lead to delays in processing this referral