**Coordinated Primary Options (CPO): Orientation**

**Background**

Coordinated Primary Options (CPO) is the delivery of services by recognised health professionals within a primary care or community care settings. These services would otherwise have been delivered by a secondary hospital-based service including outpatient services, ED services and in-patient services.

CPO was established in 2003 to address/reduce increasing acute hospital presentations and admissions as an initiative to provide alternative management options in primary care. CPO is not dependent on a patient being enrolled with a practice, meaning that enrolment does not dictate where patients access the service and removes any cost barrier for the patient. The service skills can then be optimally utilised within primary care e.g. accident and medical centers or with clinicians with advanced skill levels e.g. skin cancer removal.

This programme operates under the guidance of the Medical Advisor, Clinical Programme Coordinator and CPO Steering Group which consist of HBDHB Planning and Performance, general practice representatives and Health Hawke’s Bay (HHB) management.

The intent of CPO services are:

* A primary care led programme – enabling primary care teams to access community based services, offering alternatives to acute hospital admission
* Provide services closer to home
* Reduce acute presentation and hospitalisation
* Link patients back to primary care

A range of community diagnostic, therapeutic and logistic services are available at no cost (excluding the initial GP consultation) to the patient. Examples of these include:

* Diagnostic tests – ultrasound
* Home visits by GP and/or practice nurse
* Follow-up and return visits to GP locations
* Transportation
* Age Related Residential Care Facility
* Community IV therapy
* Access to medications

CPO Programmes

* Acute Care
	+ Cellulitis (Adult), Lower Limb DVT Suspected and Management, Tonsillitis, Pyelonephritis, Dehydration (Adult), Eczema (Child),
* Hospital Discharge
* High Cost Gynaecological and Contraception
	+ Vasectomy
	+ Ring Pessary
* Skin Cancer Pathway
* Sexual Health - Youth
* LARC Pathway for Mirena/Jaydess for Menorrhagia/or Contraception
* Restore in ARRC - Short and Intermediate Stay in Age Related Residential Care (ARRC)

When considering CPO

* Would this patient be admitted to the HBDHB?
* Can we safely look after this patient within primary care?

Access

* Patients must meet all the criteria specified in the terms and conditions of contract and be suitable for CPO
* Funding only available for the agreed pathways.
* If unsure contact Clinical Coordinator and/or the Medical Advisor.

Clinical Responsibility

Initiated in Primary Care

* **GP/NP (or delegate) takes clinical responsibility for patient management during episode of care**
* **If the patient is utilising the Restore in ARRC Pathway, the GP/NP (or delegate) must agree to take clinical responsibility for the patient for the duration of time the patient is in Age Related Residential Care (ARRC).**

A range of community diagnostic, therapeutic and logistic services are available at no cost (excluding the initial GP consultation) to the patient. Examples of these include:

* GPs Consults/ Home Visits
* NP Consults/Home Visits
* Pharmacy Prescribers (employed by the practice) for ARRC and Hospital Discharge Pathway
* Practice Nurse Consults/Home Visits
* Age Related Residential Care Facility
* Transportation
* Diagnostic Tests-Ultrasound
* IV Therapy with General Practice or Community Based Nurses referred through GP/NP
* Pharmaceuticals- Only specified non-subsidised medication.
	+ Enoxaparin
	+ Cefazolin
	+ Gentamycin
	+ Probenecid

***How can further information be obtained if the need arises?***

Health Hawke’s Bay Website <https://healthhb.co.nz/>

Clinical Programme Coordinator: sonya@healthhb.co.nz

Health Hawke’s Bay (06) 871 5646

**cpo Acute Care pathway**

Patient presents and pays for Initial Consultation with GP/NP

Would you normally refer this patient to hospital?

 **NO**

Manage patient in usual way.

Can you safely manage this patient with $300 funding for up to 5 days?

Refer patient to hospital.

Can you take clinical responsibility for this patient’s care?

Can a colleague or A&M doctor take clinical responsibility for this episode?

**NO**

**NO**

Provide services within your own practice or refer to another GP provider as required (for certain pathways)

**Complete Referral Form and submit or fax to 8734960**

**Yes**

Attach CPO number to all correspondence relating to patients episode of care including prescriptions, U/Sound requests etc.

Submit electronically or Fax a referral form to the 873 4960

**After Completion of Care:**

1. Complete Outcome/Invoice Form-electronic or manual

2. Submit forms to Health Hawke’s Bay

**Yes**

**Yes**

**NO**

**Yes**

**Referring a PATIENT TO cpo**

# *FREQUENTLY ASKED QUESTIONS*

***Which patients are eligible to access CPO Acute Care services?***

Any patient who resides in Hawke’s Bay (including Wairoa, Central Hawke’s Bay), and would have otherwise been referred acutely to hospital. Patients don’t need to be enrolled with the PHO or the practice they attend.

(Exceptions - Vasectomy, Mirena and Ring Pessary Pathway- where patients must be enrolled with HHB).

***How are services accessed for the patient?***

Complete an advanced referral form and submit. If the Clinical Coordinator assistance is required, phone (027) 245 4015.

***Who has clinical responsibility for the patient while receiving CPO services?***

By accessing CPO, the referring GP/NP (or delegate) agrees to take clinical responsibility for ongoing care for the patient in the community.

***What happens if a patient requires admission after all?***

Refer to hospital services in the usual way. It is essential that patients receive the safest and clinically appropriate treatment and are admitted when necessary – risks should never be taken to avoid an admission. CPO will pay for services already provided within primary care.

***How much can be charged for services?***

A schedule of fees is on the outcome/invoice form.

***How many days can a patient be under CPO?***

The episode of care is likely to have completely resolved in five days.

***Can the practice team provide CPO services?***

Yes. Some examples of practice based services are:

* Practice nurse consultation or observation
* Intravenous therapy
* General Practitioner / Nurse Practitioner / Practice Nurse home visits
* Pharmacy Prescriber employed by the practice (ARRC and Hospital Discharge Pathway)

***Can I refer to another General Practitioner if I don’t provide this service?***

Yes, you can refer to another GP within the practice, another practice or an A&M Centre.

***How are practice-based services claimed back?***

Complete claiming on the CPO Advanced form and submit electronically.

You will receive payment by the 20th of the month if all documentation is in order.

***Does the patient pay for CPO?***

No. Their initial GP consultation incurs the usual practice charge and thereafter, all services are provided at no cost to the patient.

***Can the practice claim GMS or is their claw back for seeing patients not enrolled within the practice.***

GMS and claw-backs are not able to be claimed under CPO

***Can CPO services be accessed for the same patient for more than one episode of care?***

Yes, funding is allocated per patient, per episode of care.

***Are there some conditions not covered by CPO?***

* Only conditions specified as pathways are funded under CPO

***Who can provide with clinical support***

* Dr Alan Wright, CPO Medical Advisor

Telephone: (06) 873-8999

* Appropriate Registrar at HBDHB
* Physician of the Day at HBDHB

***Accessing CPO Forms***

***Acute Care/Hospital Discharge/Ring Pessary/ Vasectomy/EngAGE/LARC***

Select the menu options Module -> Advanced Forms -> New Form (**Shift+F3)** or from within the Patient Manager ->Forms ->New Form.

Choose the ‘Halcyon Provider Portal’ form, Click OK - choose the appropriate form for referral

***Skin Cancer Pathway***



***Sexual Health***

Select the menu options Module -> Advanced Forms -> New Form (**Shift+F3)** or from within the Patient Manager ->Forms ->New Form.

Choose the ‘Halcyon Provider Portal’ form, Click OK- click on Sexual Health

**CPO Programmes**

See Health Hawke’s Bay website healthhb.co.nz for further information on each CPO programme and individual pathways.

**ACUTE CARE PATHWAYS**

Aims

* Transitioning of services from secondary care to primary care
* Deliver health care services closer to home

Criteria

* Available to all Hawke’s Bay Residents
* Can be utilised by all Hawke’s Bay GPs/NPs.
* **Only Clinical Pathways listed below will be accepted- There can be no exceptions.**

Clinical Pathways

* Cellulitis
* Back Referral from ED for cellulitis
* DVT Confirmed/Excluded
* Back Referral from ED for DVT
* Childhood Eczema
* Pyelonephritis
* Tonsillitis/Quinsy
* Constipation in Children
* Dehydration/Rehydration including minor hyperemesis

Exclusions

* Maternity (except minor Hyperemesis)
* Palliative Care

ED Back Referral for Cellulitis

Initiated by ED staff HBDHB referring patient back to GP or A&M Centre for patients with cellulitis requiring IV Therapy. General practice is required to complete the CPO Referral.

**HOSPITAL DISCHARGE PATHWAY**

Aims to reduce hospital re-admission rates, support re-engagement with primary care at transition and provide seamless service from secondary to primary care with improved support for ongoing chronic disease management.

Funding

CPO funds **1** consultation with the GP, NP or Pharmacy Prescriber (employed by the practice) following discharge any HBDHB Hospital, including Wairoa and Central Hawke’s Bay.

Consultations can be either face to face or through virtual means (telephone, video etc).

Access Criteria:

1. Hawke’s Bay Resident
2. Māori, Pasifika or Reside in Quintile 4 or 5 or hold a current Community Service Card **AND**,
3. **The patient will have been an in-patient for 1 night or more AND**
4. Service must be delivered within **14 days** of discharge from hospital **AND**
5. The patient will have had an admission for one or more of the following:
* Cardiac conditions – includes cardiac surgery, myocardial infarction, hypertension.
* heart failure
* Gastro-intestinal
* Abdominal surgery
* Respiratory- asthma, , Pneumonia
* COPD
* Musculoskeletal
* Neurological, CVA/TIA
* Renal
* Cellulitis & Infection
* Diabetes
* Breast Surgery

Exclusions

* Admissions following acute trauma or ACC covered conditions
* Private hospital patients unless under HBDHB contract
* Maternity Care except severe hypertension requiring follow up post pregnancy
* Mental Health
* Minor admissions e.g. dental
* Treatment at A&M or after hours centers
* Follow up from Outpatients

Entry into Pathway

* Initiated by GP, NP or Pharmacy Prescriber (employed by the practice) or from HBDHB Specialists back to the GP

Medication Review

* Patients to have medication review as part of this pathway

**VASECTOMY PATHWAY**

Provides long term contraceptive health for those unable to afford Vasectomy for those of the lower socio-economic group particularly Māori, Pacific and those living in Geocode 4 and 5 areas

Background

* Available for Vasectomy only
* High Cost Contraception HHB contract available to HHB enrolled population only
* If GP unable to provide service- refers to another GP or practice to provide service.

Criteria

**MAORI, PACIFIC, QUINTILE 4 or 5 or COMMUNITY SERVICES CARD**

**Ring Pessary**

A funded pathway for a small number of women who require ring pessary changes. These patients must be assessed by the Gynaecology clinic prior to accessing this pathway.

**SKIN CANCER EXCISION PATHWAY**

A funded Skin Cancer Excision Pathway, for medium complexity skin cancer excisions, for eligible people domiciled in Hawke’s Bay to be delivered in the community by accredited general practitioners, free of charge to eligible patients.

Access:

* Residents of Hawke’s Bay (not necessarily enrolled patients)

CPO Service Scope:

The primary care CPO Skin Cancer Excision Service specifically covers:

* Lesions highly suspicious of Melanoma or growing non-melanoma skin cancer- BCC, SCC
* Excision of up to two lesions (undertaken consecutively) of medium complexity by an accredited GP provider.
* Follow up appointment with the accredited GP provider for removal of sutures and discussion of pathology.

Exclusions:

|  |  |
| --- | --- |
| * squamous cell carcinoma in situ on trunk or limbs
 | * benign naevi
 |
| * superficial basal cell carcinoma
 | * all other non-malignant lesions
 |
| * seborrhoeic keratoses
 | * non-healing ulcers
 |
| * lipomas
 | * chrondodermatitis nodularis helicis ears
 |
| * sebaceous cysts
 | * pyogenic granuloma
 |
| * warts
 | * epidermoid cyst
 |
| * solar keratoses
 | * pilar tricholemmal cysts
 |
| * dermatofibroma
 | * milia
 |
| * Staged Procedures
 | * Non-surgical management e.g. topical treatment
 |

HHB Skin Lesion Coordinator Triage Process:

Patients with lesions suspicious of cancer, requiring surgical removal, can be referred into the CPO Skin Cancer Pathway. All referrals will be triaged at Health Hawke’s Bay and referred either:

* Directly to an accredited GP provider for excision of the skin lesion.
* To the CPO Medical Advisor for triage to primary or secondary care or declined if inappropriate
* To HBDHB if lesions are complex lesions and unable to be completed in primary care
* Returned to referring GP/NP if inappropriate, incomplete information or no photographs received.

When referring there are two steps in the process:

1. Photographs (less than 2MB) are taken of the lesion/s and emailed to skinlesions@healthhb.co.nz noting site and CPO / NHI number in subject line (please do not include patient identifying data).
2. Complete skin lesion referral form and submit electronically.

**SEXUAL HEALTH PATHWAY**

This pathway provides youth timely access to sexual and reproductive health services. This is delivered within primary care through contracted practices by clinically skilled staff and is free of charge to the patient.

Access

* Eligible patients are 20 years and under, with the exception of Wairoa where eligible patients are 24 years and under
* Domiciled within the Hawke’s Bay region
* Entry for eligible patients is by referral from any source including self-referral

Exclusions

* Any service for which alternative funding sources are specifically provided are excluded from the scope of this service
* Domiciled outside Hawke’s Bay
* Contraception patients that are funded through the Ministry of Social Development.

The following services are not included in the scope of this service:

* Specialist Sexual Health Services
* Sexual Abuse and Assault Services (including forensic, non-forensic, historical and paediatric services)
* Termination of pregnancy counselling services
* Primary medical consultations outside of this service
* School based nursing and GP services, youth health service, whanau ora services

Pharmaceuticals

Supply of pharmaceuticals will be provided by Hawke’s Bay District Health Board and provided to the practice through a faxed order form provided to each practice. Medications are provided to patients at no cost. Medications are only for patients eligible for the CPO Sexual Health Pathway.

Service funding and co-payments

* Eligible patients will not be liable for any co-payments.
* There will be no claw-backs charged by GPs/NPs when treating casual patients and a CPO claim is made.

**LARC PATHWAY FOR MIRENA/JAYDESS**

This pathway funds the insertion cost of Mirena (Contraception and Menorrhagia) or Jaydess for Contraception for eligible patients according to access criteria below.

**Access Criteria:**

* **Māori, Pacific or reside in Quintile 5**
* Enrolled with Health Hawke’s Bay

If the patient meet access criteria, CPO will fund the insertion costs for the Mirena or Jaydess. The Mirena and Jaydess device is available on prescription through the Pharmacies, with the patient funding the prescription fee.

**RESTORE in ARRC**

Provides funding to support stay in Aged Related Residential Care (ARRC) for short or intermediate stay.

**Visits to ARRC Facility**

* Consultations can be provided by either the patients GP/NP (or delegate), Pharmacy Prescriber or a Registered Nurse (RN) under the instruction of their GP/NP (or delegate).
* Telephone consultation/s between the GP/NP/Prescribing Pharmacist and the ARRC RN are funded while the patient is in the ARRC under the CPO Programme.

The GP/NP (or delegate)

* **Must agree to take clinical responsibility for the patient while they are in the ARRC facility under CPO.**
* Complete the CPO referral form and provide the ARRC facility with the valid unique CPO reference number

**Short Stay**

The Restore in Aged Related Residential Care (ARRC) Short Stay covers three pathways:

1. GP Short Stay, including Respiratory Short Stay
2. Non-Weight Bearing Stay
3. Convalescence Flexi Stay

**Pathways**

**(a) GP Short Stay**

Service Users

* Aged 65 years of age or older or
* Aged 50 to 64 with age related needs and
* Reside in Hawke’s Bay DHB region
* require very little or no therapy input but are unable to manage at home temporarily (up to 8 days) with referral and input from the primary care team);
* the lead referrer is the patient’s GP/NP (or delegate) and only rest home level of care is available. No prior approval required.
* Locate appropriate bed availability with a contract ARRC facility;
* Ensure service user enters the ARRC facility with the appropriate medication for their stay.

**(b) Non-Weight bearing Stay**

Service Users

* Aged 18 years of age or older
* Reside in Hawke’s Bay DHB region
* for patients who are appropriate for an aged related residential setting with orthopaedic injuries that preclude them from going home, with referral and input from CNS Orthopaedics in conjunction with orthopaedic consultant and their own GP/NP (or delegate)
* the lead referrer is the HBDHB CNS Orthopaedics who will determine the appropriate level of care (rest home or hospital), whom will provide clinical input during the stay.

**(c) Convalescence Flexi Stay**

Service Users

* Aged 18 years of age or older or
* Reside in Hawke’s Bay DHB region
* require very little or no therapy input but are unable to manage at home short-term with referral from CNS Gerontology in conjunction with their own GP/NP (or delegate), input may be from another CNS;
* The lead referrer is the HBDHB CNS Gerontology whom will determine the appropriate level of care (rest home of hospital), whom will provide clinical input during the stay. The lead referrer is responsible for submitting the Admission notification, and the ARRC facility is responsible for submitting the Discharge Notification

**Exclusions:**

* *Patients who require residential care to provide respite to the carer who lives with them (carer fatigue/ carer unavailable for a period). Patients who are highly dependent on a live-in carer should be referred to NASC HB for assessment of eligibility for a respite allowance. Those with a respite allowance can make arrangements with an ARRC facility directly.*
* *Patients who require rest home admission for mental health issues.*
* *Patients who are Palliative. Pathway for up to 2 weeks funded residential care is in place through NASC HB.*
* *Patients expected to require longer than 8 days and need MDT in-put should be referred to the Intermediate care service. Please refer to the engAGE in ARRC Intermediate Care Service.*

**Intermediate Stay**

Older people can be admitted to this service from their own homes or from the acute hospital and receive input from the engAGE MDT service. The GP/NP agrees to take clinical responsibility for the patient while they are in the Age Related Residential Care (ARRC) facility. Patient visits by GP/NP/practice nurse are funded under CPO, and the ARRC facility charges will be funded directly by HBDHB.

GP/NP can access Intermediated Stays in ARRC for up to six weeks.  Access to Intermediate Care Beds (ICB) occurs as either:

* 1. Admission from patient’s home.
	2. Admission from acute hospital (transition to home).

***Service Users***

* ***Aged 65 years of age or older or***
* ***Aged 50 to 64 with age related needs and***
* ***Reside in Hakes Bay DHB region***

***Criteria:***

* *A person who is medically stable but is not quite well enough to be at home/ return home from hospital. This may be for ongoing clinical management or for increased supports for a short period of time due to deconditioning.*
* *Person can be managed safely in an ARRC Facility*
* *Person consents and whanau notified*
* *Person’s GP/NP or another GP /NP (i.e. a covering GP from same centre) must accept clinical responsibility for the person. This includes weekly GP/ NP/practice nurse visits to the facility and attendance at the engAGE MDT meeting.*
* *GP/NP/practice nurse visits to the ARRC facility will be funded by CPO, therefore CPO documentation essential.*
* *There must be documented goals with the goal to discharge home after a period of support, within an agreed timeframe being essential.*

***Exclusions:***

* *If the person requires permanent placement in an ARRC facility - assessment must be undertaken on the ward for placement by Options HB.*
* *People that could be managed at home with a package of care from Options or ACC should be referred for same and discharged home/ remain at home. Referral for engAGE MDT follow up at home could be considered.*
* *Medically unstable and/or needing inpatient investigations or inpatient care.*
* *End of life palliative patients. Pathway for up to two weeks funded residential care is in place through Options HB.*
* *Patient awaiting significant housing modifications or permanent placement under the PPPR Act.*

**Finding an Available Bed**

GPs/Practice Nurses can use the Elder Net Website ([www.eldernet.co.nz](http://www.eldernet.co.nz)) to identify which facilities have vacant beds. Follow the “Residential Care Vacancies” Quick Link at the bottom of the home page. This list is updated daily.

**Contracted ARRC Facilities**

\*\* Please note that only the facilities in the left hand column have a contract to provide Intermediate Care. If a person is in a Short Stay bed but goes on to require Intermediate Care and they are not in a facility that has a contract to provide this, they will need to move to one of the facilities in the left hand column for their Intermediate Care stay. If it is anticipated that a person may need Intermediate Care, they should only be placed in a facility from the left hand column.

|  |  |
| --- | --- |
| **engAGE in ARRC – Intermediate & Short Stays** | **engAGE in ARRC – Short Stays ONLY \*\*** |
| Atawhai Care | Bardowie Retirement Complex |
| Brittany House | Bryant House |
| Duart Care | Eversley Care |
| Glengarry Rest Home & Hospital | Gladys Mary Rest Home |
| Gracelands Care | Greendale Residential Care |
| Mary Doyle Trust Life Care | Otatara Heights Residential Care |
| Mt Herbert House | Roseanne Retirement |
| Princess Alexandra Retirement Village | Voguehaven Rest Home |
| Radius Hampton Court | Waverley House Rest Home |
| Summerset in the Bay | Woburn Rest Home |
| Summerset in the Vines |  |
| Taradale Masonic Residential Home |  |
| Waiapu House Rest Home |  |

**service providers**

**Radiology**

Ultrasounds are available under the CPO contract for Suspected DVT Lower Limb. Ultrasounds can be obtained through the following providers

|  |  |  |
| --- | --- | --- |
| **Address** | **Telephone** | **Fax** |
| TRG Imaging HastingsProspect RoadHASTINGS | 873-1166 | 873-1167 |
| TRG Imaging NapierKennedy RoadGreenmeadowsNAPIER | 845-3306 | 845-3307 |
| TRG Imaging Gisborne75 Customhouse StreetGisborne 4010 | 06 867-0736 |  |
| Onsite UltrasoundUnit 362 Munroe StreetNAPIER | 080 991119 | 835-1705 |
| Onsite UltrasoundCanning RoadHASTINGS | 0800 991119 | 870-4403 |
| Unity Specialists and Ultrasounds102 Queen Street East HASTINGS  | 281-2797 | 281-2798 |
| Ultrasound Hawke’s Bay5/24 Porter DriveHAVELOCK NORTH | 06 650 6744 |  |

* All referrals must have a completed associated referral form with the CPO reference number included. CPO Reference number is obtained through the CPO Advanced form- top left hand corner e.g.: HB1234
* Patients may access a taxi if necessary (using Hastings Taxis). Please ensure the taxi driver knows not to wait while the procedure is performed.
* Ultrasounds are usually available on the same day requested.

**Pharmacy**

All medications prescribed under CPO pathways can only be supplied from the below pharmacies. These are IV cefazolin, gentamycin, enoxaparin and oral probenecid,

|  |  |  |
| --- | --- | --- |
| **Provider** | **Phone** | **Fax** |
| The PharmacyThe Hasting Health Centre303 St Aubyn Street WHASTINGS  | 873-8585 | 873-8586 |
| Unichem Munroe St Pharmacy32 Munroe StreetNAPIER | 834-0884 | 873-8586 |
| Taradale Medical PharmacyTaradale Medical CentrePuketapu RoadTARADALE | 845-2790 | 845-1583 |

1. A small stock supply of the above medications will be supplied to each general practice to initiate treatment
2. A prescription for the full course of the required medication is generated for the patient and faxed to one of the above pharmacies, which can be delivered or picked up by the patient and returned to the practice for the remaining treatment
3. All prescriptions MUST have the CPO reference number included. CPO Reference number is obtained through the CPO Advanced form- top left hand corner e.g.: HB1234
4. Medication not utilised can be used as stock for the practice, replacing what has been utilised
5. Medications available on the MPSO or prescriptions given at the completion of the episode of care i.e.: oral antibiotics, dexamethasone, intravenous saline (1L) not included.

NB: Sexual Health Pathway Medication excluded

**Transport**

The Coordinated Primary Options taxi service, through Hasting Taxis, may be used to transport patients to and from any of the CPO Service Providers.

|  |  |
| --- | --- |
| **Provider** | **Phone** |
| Hastings Taxis303 Railway RoadHASTINGS | 878-5055 |

When ordering a taxi you must:

1. State that it is a Coordinated Primary Options pick-up and should be charged to the CPO account. Also provide the CPO reference number and name of the patient
2. CPO Reference number is obtained through the CPO Advanced form - top left-hand corner e.g: HB1234
3. Transport is available within the Hastings and Napier City Boundaries.

**Community IV Therapy Provider**

For patients requiring IV therapy, who are unable to come into the surgery and are suitable to receive IV Cefazolin in their homeor rest home.

**The responsibility of care remains with the referring General Practitioner/Nurse practitioner**

|  |  |  |
| --- | --- | --- |
| **Provider** | **Contact** | **Phone/Fax** |
| Health Care NZ Hawke’s BayPO Box 95321 Browning StreetNAPIER | Community IV Nurse | Phone 834-4214Mobile: 021 925 987Fax: 834-4215 |

For this service to commence, please contact the Community IV Nurse on 021 925 987. The GP/NP needs to complete the Community IV Referral Form (found in OUTBOX in PMS) and fax to 834 4215 before 2.00pm.

* The original referral form must be posted to:

IV Community Nurse

PO Box 953

Napier 4140

Key points for Referral Form:

* The prescription component of the form must be written in legible writing and signed by the prescribing doctor
* The first dose of the drug must be given within the general practice/ Afterhours Medical Centre
* The referral form must be faxed to **834 4215** **before 2.00pm Monday to Friday**, if you wish the nurse to commence IV therapy on that day.
* The GP is able to utilise the nurses am, pm or both. (You need to specify this on the referral form.)
* A contact number of the prescribing GP must be available for the nurse, including an after-hours number.
* GPs will be contacted if the patient’s condition deteriorates; the IV tissues or the nurse has concerns with the patient’s condition.
* Patients are advised to visit their GP at the completion of treatment
* There is weekend and public holiday cover if the patient has commenced treatment prior to the weekend or public holiday. No new referrals are able to be accepted over a weekend or a public holiday.

NB: The cost for this service will be included as part of the package of care with an anticipated value of $300.