

Fill in only if patient label is unavailable

Name: DoB:

NHI: Phone:

Address:

**SPRINGHILL EARLY EXIT PLAN**

# SPRINGHILL EARLY EXIT PLAN - 2024

This form is designed to ensure your client’s safe return to your care.

Be aware the persons below will be contacted should your client leave the Springhill programme early or prior to their planned discharge date. Please ensure the information you provide is accurate.

Please note that the Hawkes Bay District Health Board will not provide funds for travel or accommodation costs for your client’s return journey. It is the individual resident’s and agency’s responsibility to fund travel and accommodation in the event of early discharge.

|  |  |
| --- | --- |
| Address to be discharged to: |  |
| Referrer’s name: |  |
| Referrer’s email address: |  |
| Referrer’s contact numbers: *(including out of hours)* |  |
| Contact name: |  |
| Relationship to client: |  |
| Contact numbers: *(including out of hours)* |  |
| Other supports to be contacted: |  |
| Contact numbers: |  |

**Declaration**

I understand the important of this exit plan and have provided information that is accurate and correct to the best of my knowledge.

Signed (Referrer): Date:

Signed (Client): Date: