Application number……..

St. Bartholomew's House
Reconnecting lives.

REFERRAL FORM FOR RESIDENTS OF ARNOTT VILLAS

This comprehensive referral form will be used to assess suitability of applicants for accommodation at Arnott Villas – Kelmscott.

Please take sufficient time to complete this document thoroughly in collaboration with the applicant to obtain all relevant and accurate information.

Incomplete referrals will be returned, resulting in a delay in providing potential accommodation.

Please ensure the information you provide is comprehensive and accurate. Before submitting the referral, please ensure each box below has been addressed to avoid the referral being returned.

HAVE YOU AND THE APPLICANT (please tick if task is completed):

☐ RECEIVED AND READ THE INFORMATION BROCHURE FROM ST BARTHOLOMEW'S HOUSE (APPLICANT)

☐ OBTAINED APPROVAL IF THE APPLICANT HAS A GUARDIAN

☐ VIEWED THE POTENTIAL ACCOMMODATION

THIS REFERRAL REQUIRES THE FOLLOWING (please tick if task is completed):

☐ ATTACH APPROVAL IF THE APPLICANT HAS A GUARDIAN

☐ COMPLETE ALL THE QUESTIONS IN FULL INCLUDING THE RISK ASSESSMENT

☐ ATTACH A CURRENT STATEMENT OF INCOME FROM CENTRELINK OR DEPARTMENT OF VETERANS AFFAIRS OR TWO RECENT PAYSLIPS IN SUPPORT OF THE APPLICATION

☐ ATTACH A MANAGEMENT CARE PLAN AND CRISIS MANAGEMENT CARE PLAN

☐ SIGN ALL DECLARATIONS, CONSENTS AND AGREEMENTS

IF YOU HAVE ANY FURTHER QUESTIONS RELATING TO COMPLETING THIS REFERRAL PLEASE CONTACT THE SITE COORDINATOR ON TELEPHONE NUMBER 08 9323 5161

Please send the completed referral (marked confidential) to: The Site Coordinator, Arnott Villas, Unit 12/20 Arnott Court, Kelmscott WA 6111

St. Bartholomew's House
Reconnecting lives

AGREEMENT FOR RELEASE AND EXCHANGE OF INFORMATION

I _____

Of _____

Hereby authorise

St Bartholomew's House _____

Case manager/Mental Health Service_____

CRU Liaison Officer _____

Psychiatrist_____

Carer_____

Other (please specify)_____

To release details of my relevant mental health history and treatment for the purpose of securing and maintaining long term accommodation.

This authorisation is for the release of information that will be disclosed and held in a confidential manner.

Effective from…….. to ……

Signed_____ Signed_____
Applicant Guardian (if applicable)

Date_____ Date_____

Signed_____
Witness

Date_____

Application Number……..

Referrer Details

Name of Referrer _____ Position _____

Address _____ Contact Phone Number _____

Applicant Details

Surname _____ Given Names _____

Date of Birth _____ Religion _____

Ethnicity _____ Indigenous □ Yes □ No

Preferred language _____ Require assistance reading or writing □ Yes □ No

Current Address _____

Contact Phone Number _____ Mobile _____

Relationship/Marital Status (ie. single/divorced/in a relationship?) _____

Gender (please circle) Male Female Other Does not wish to identify

Do you have any children? □ Yes □ No If yes frequency of contact _____

Income/Payment Type _____ Centrelink Number _____ Expiry Date _____

Does someone else manage your money? □ Yes □ No Name _____

Address _____ Phone Number _____

Do you have an appointed Guardian? □ Yes □ No

If yes, who is your Guardian? _____ Phone Number _____

Address _____

Next of Kin _____

Relationship _____

Address _____

Contact Phone Number _____ Mobile _____

Health Professional contact details in case of emergency _____

Address _____ Contact Phone Number _____

General Practitioner _____

Address _____ Contact Phone Number _____

Chemist/Pharmacy details _____

Address_____ Contact Phone Number _____

Medicare Number _____ Expiry Date _____ Private Health Cover? □No □Yes_____

To be completed by the the client with the referrer

1. WHAT TYPE OF ACCOMMODATION ARE YOU CURRENTLY LIVING IN?
(PLEASE TICK ALL APPLICABLE OPTIONS)

□	Privately owned	□	Rental	□	Homeswest	□	Hostel
□	Homeless	□	Hospital	□	Family	□	Friends
□	Short term/crisis accommodation			□	Other _____		

How long have you lived in your current accommodation? _____

2. DO YOU HAVE ANY PHYSICAL/HEALTH ISSUES OR DISABILITY?

Diabetes	□ YES	□ NO	Bruise or bleed easily	□ YES	□ NO
Heart complaints	□ YES	□ NO	Ulcer	□ YES	□ NO
Liver disease	□ YES	□ NO	Asthma	□ YES	□ NO
Epilepsy	□ YES	□ NO	Allergies	□ YES	□ NO
HIV/AIDS	□ YES	□ NO	Allergic to medication	□ YES	□ NO
Hepatitis	□ YES	□ NO	Are you pregnant	□ YES	□ NO
Blood pressure	□ YES	□ NO	Acquired Head Injury	□ YES	□ NO
Speech	□ YES	□ NO	Thyroid problems	□ YES	□ NO
Visual	□ YES	□ NO	Eating Disorders	□ YES	□ NO
Hearing	□ YES	□ NO	Substance abuse	□ YES	□ NO
Mobility impairments	□ YES	□ NO	Other	□ YES	□ NO
Respiratory disease	□ YES	□ NO			

If yes please give more details, identify the impact on your life and your support needs in relation to these _____

3. HOW DO YOU RATE YOUR LEVEL OF ALCOHOL CONSUMPTION?

□ NEVER □ SPECIAL OCCASSIONS □ WEEKLY □ DAILY

Do you consider your alcohol consumption to be a problem? □ YES □ NO

If so, have you sought help to address this problem? □ YES □ NO

4. HOW DO YOU RATE YOUR LEVEL OF SUBSTANCE USE INCLUDING CIGERETTES?

□ NEVER □ SPECIAL OCCASSIONS □ WEEKLY □ DAILY

Do you consider your substance use a problem? □ YES □ NO

If so, have you sought help to address this problem? □ YES □ NO

5. ANY CURRENT LEGAL ISSUES? □ YES □ NO

If yes please give details: _____

_____

This section is to be completed by the REFERRER

Please ensure you complete the risk assessment included, detailing an accurate current and historical account.

DIAGNOSIS _____

HISTORY OF PRESENTING PROBLEMS AND SYMPTOMS (INCLUDING CURRENT MENTAL HEALTH PRESENTATION) _____

_____

_____

_____

_____

_____

WHY DO YOU THINK THIS PERSON WOULD BE SUITABLE FOR ACCOMMODATION AT ARNOTT VILLAS?

_____

_____

_____

_____

KEY AREAS WHICH WOULD BENEFIT FROM ATTENTION AND SUPPORT?

□ Homecare skills

□ Improving self/personal care

□ Community integration/connection

□ Development of social networks

□ Development of day structure/activities

□ Improving or maintaining mental health.

□ Improving or maintaining physical health

□ Managing medications

□ Symptom management/Relapse prevention

DESCRIBE ANY DIFFICULTIES WITH MEDICATIONS OR TREATMENT

_____

_____

_____

_____

COMMUNITY TREATMENT ORDER □ YES □ NO Expiry Date:_____

Risk Identification Form

Date: _____ Time: _____ Location: _____

Print Name of Clinician: _____ Signature: _____

Clinical Assessment Point (√ if present)	
First contact with the Service	
Change of transfer of care	
Change in legal status	
Occurrence of a significant life event	
Change in mental state	
3 Monthly review	
Other	

Source of information (√ if present)	
The consumer	
Primary Carer/ Principal Care Giver	
Assessing clinicians knowledge of the consumer's past behaviour and current clinical presentation	
Previous clinical records; other health sources (e.g., GP)	
Other informants (eg., family, friends, work colleagues)	
Police and other individuals and agencies	
Other	

Factors in the Person's HISTORY AND MENTAL STATE that may <u>increase</u> risk	Historical	√ if Current	√ if NOT explored
Harm to self – Threat			
Harm to self – Actual Harm			
Suicide attempt			
Harm to other – threat physical harm			
Harm to others – actual physical harm			
Harm to others – threat to kill			
Damage to property			
Past or current assault charge			
Fire setting			
Wandering/ disinhibition			
Others (e.g. abuse, bullying)			
THE ABOVE WAS/ IS SECONDARY TO:			
Low mood			
Elated mood			
Delusional or other disorder of thought			
Hallucinations/ altered perception			
Cognitive disturbance			
Impulsiveness			
Personality factors			
Other psychopathology (elaborate)			

Other factors that may increase risk	√ if significant
Parents/ carers have significant physical/ mental disability and/ or substance abuse	
Relationship problems	
Physical illness or disability	
Absence or supports/ lives alone/ social isolation	
Arrest or criminal charges	
Criminal conviction	
Persecution or threats from others	
Loss, including death	
Financial stress	
Substance abuse, intoxication or withdrawal **GIVE DETAILS BELOW**	
Past history of child abuse or other abuse	
Access to weapons	
Access to medication (risk of overdose)	
OTHER CONCERNS	
Lack of support systems	
Individual's attitude	
Compliance	
Reliability	
Concern expressed by significant others	

RISK IDENTIFICATION FORM

<u>Elaborate on Risk Factors Identified</u>
Enter Dates of other significant reports detailing risks identified.

RISK ALERTS
☐ Data entered in PSOLIS (√ when completed)
☐ Risk alerts entered on PSOLIS (√ when completed)

Comments:_____

_____

_____

_____

COMMENTS \ ADDITIONAL INFORMATION TO ASSIST THIS REFERRAL

DECLARATION BY APPLICANT/OR GUARDIAN

I DECLARE THE APPLICANT INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT

SIGNED_____
APPLICANT

DATE_____

DECLARATION BY REFERRER

I DECLARE THE REFERRER INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNED_____
REFERRER

DATE_____

DECLARATION BY REFERRER

I DECLARE THAT ALL INFORMATION IN THIS REFERRAL HAS BEEN CHECKED AND IS

ACURATE AS OF (Date) _____

SIGNED_____
REFERRER

DATE _____

Referal feedback:
If you have any comments regarding the format of this referral form please detail below.

_____

_____

_____

_____