



## REFERRAL FORM FOR RESIDENTS OF BENTLEY VILLAS

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

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 5163

Please send the completed referral (marked confidential) to: The Site Coordinator, Bentley Villas, Unit 2/1 Channon Street, Bentley WA 6107

## 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 \_\_\_\_\_  
Applicant

Signed \_\_\_\_\_  
Guardian (if applicable)

Date \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_  
Witness

Date \_\_\_\_\_

**Referrer Details**

Name of Referrer \_\_\_\_\_ Position \_\_\_\_\_

Address \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

**Applicant Details**

Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Date of Birth \_\_\_\_\_ Religion \_\_\_\_\_

Ethnicity \_\_\_\_\_ Indigenous  Yes  NoPreferred 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 \_\_\_\_\_



**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 BENTLEY 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)			
<b>THE ABOVE WAS/ IS SECONDARY TO:</b>			
Low mood			
Elated mood			
Delusional or other disorder of thought			
Hallucinations/ altered perception			
Cognitive disturbance			
Impulsiveness			
Personality factors			
Other psychopathology (elaborate)			

**Elaborate on Risk Factors Identified**

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Enter Dates of other significant reports detailing risks identified.

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 <b>GIVE DETAILS BELOW</b>	
Past history of child abuse or other abuse	
Access to weapons	
Access to medication (risk of overdose)	
<b>OTHER CONCERNS</b>	
Lack of support systems	
Individual's attitude	
Compliance	
Reliability	
Concern expressed by significant others	

**RISK ALERTS**

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Data entered in PSOLIS (✓ when completed)

Risk alerts entered on PSOLIS (✓ when completed)

**Comments:** \_\_\_\_\_

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**RISK IDENTIFICATION FORM**



**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 \_\_\_\_\_

**Referral feedback:**

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

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