



REFERRAL FORM FOR RESIDENTS OF SUNFLOWER VILLAS

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

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 5164

Please send the completed referral (marked confidential) to: The Site Coordinator, Sunflower Villas, Unit 16/15 Limosa Close, Stirling WA 6021

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 _____

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)

- | | | | |
|--|--------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Privately owned | <input type="checkbox"/> Rental | <input type="checkbox"/> Homeswest | <input type="checkbox"/> Hostel |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Hospital | <input type="checkbox"/> Family | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Short term/crisis accommodation | <input type="checkbox"/> Other _____ | | |

How long have you lived in your current accommodation? _____

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

- | | | | | | |
|----------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bruise or bleed easily | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart complaints | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ulcer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Liver disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Allergies | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HIV/AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Allergic to medication | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Are you pregnant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Acquired Head Injury | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Speech | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Visual | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Eating Disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hearing | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Substance abuse | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mobility impairments | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Other | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Respiratory disease | <input type="checkbox"/> YES | <input type="checkbox"/> 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 SUNFLOWER 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 increase 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) | | | |

Elaborate on Risk Factors Identified

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 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 ALERTS

Data entered in PSOLIS (✓ when completed)

Risk alerts entered on PSOLIS (✓ when completed)

Comments: _____

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.
