Application number………..

REFERRAL FORM FOR RESIDENTS OF SWAN VILLAS

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

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 5162

Please send the completed referral (marked confidential) to: The Site Coordinator, Swan Villas, Unit 3 91 Patterson Drive, Middle Swan WA 6056

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 SWAN 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.

____

____

____

____