



St. Bartholomew's House
Reconnecting lives.

REFERRAL FORM FOR APPLICATIONS FOR RESIDENCY With St Bartholomew's Community Recovery Villages

This comprehensive referral form will be used to assess suitability of applicants for accommodation at St Bartholomews Community Recovery Villages across the sites.

Please tick the site you are applying for:

- Arnott Village in Kelmscott
- Bentley Village in Bentley
- Sunflower Village in Stirling
- Swan Village in Middle Swan

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

Incomplete or illegible 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

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 PAYSLEIPS 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 CONTACT DETAILS BELOW

Please send the completed referral (marked confidential) to:

The Site Coordinator, Arnott Villas, Unit 12/20 Arnott Court, Kelmscott WA 6111
Telephone; **08 9323 5161** or Email Sitecoordinator.av@stbarts.org.au

The Site Coordinator, Bentley Villas, Unit 2/1 Channon st Bentley WA 6102. Telephone;
08 9323 5163 or Email sitecoordinator.bv@stbarts.org.au

The Site Coordinator, Sunflower Villas, Unit16/15 Limosa Close, Stirling 6021. Telephone;
08 93235164 or Email; sitecoordinator.sv@stbarts.org.au

The Site Coordinator, Swan Villas, Unit 3/91 Patterson Drive, Middle Swan 6056.
Telephone; **08 9323 5162** or Email; sitecoordinator.swv@stbarts.org.au



St. Bartholomew's House
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AGREEMENT FOR RELEASE AND EXCHANGE OF INFORMATION

I _____

Of _____

Hereby authorise

St Bartholomew's House _____

Case manager/Mental Health Service _____

CRV 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 supported 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 (i.e. single/divorced/in a relationship?) _____

Gender: Male Female Other Does not wish to identifyDo 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 applicant 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 OCCASIONS 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 CIGARETTES?

- 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 COMMUNITY RECOVERY VILLAGES?

KEY AREAS WHICH WOULD BENEFIT FROM ATTENTION AND SUPPORT?

- Home care and independent living skills
- Improving self/personal care
- Community/Family 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 Applicant	
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 (e.g., 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)			

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.
