St Bart's

REFERRAL FORM-Integrated Services

This Referral Form is for St Bart's Integrated Services. It should be completed with the applicants consent and, ideally, in the presence of. Please ensure all sections are completed, with the relevant supporting documents attached, before sending it to the Intake and Admission Coordinator (intake@stbarts.org.au).

Please note incomplete or illegible referrals will be returned, resulting in processing delays. Referrals will also be deemed incomplete until all of the applicable information has been received.

REFERRER DETAILS

Referrers name:	**Date of referral:** / /
Organisation:	**Position:**
Email:	**Phone:**

ST BART'S INTEGRATED SERVICES

Which service/s are you applying for (tick all that apply):

- ☐ Future Homes [FH] Men's Service
- ☐ Kensington Street [KS] Women's Service
- ☐ Bart's Plus [B+] Family Service
- ☐ Arnott Community Recovery Village [ACRV]
- ☐ Bentley Community Recovery Village [BCRV]
- ☐ Sunflower Community Recovery Village [SCRV]
- ☐ Swan Community Recovery Village [SwCRV]
- ☐ Cannington Accommodation Unit [CAU]
- ☐ Medina Accommodation Unit [MeAU]
- ☐ Midland Accommodation Unit [MiAU]

For all enquiries, please contact the Integrated Services Intake and Admissions Coordinator at intake@stbarts.org.au or call (08) 9323 5124.

SUPPORTING DOCUMENTS

Please include the following information with your referral (if applicable):

- ☐ Primary diagnosis of a Mental Health disorder*
- ☐ Current Mental Health Care Plan (if applicable)
- ☐ Client Management Plan (including PSOLIS alerts)*
- ☐ Current National Disability Insurance Scheme [NDIS] Plan (if applicable)
- ☐ Brief Risk Assessment completed by a clinician*
- ☐ Recent Discharge Summaries (if applicable)
- ☐ Medication regimen or Community Treatment Order [CTO]*
- ☐ Physical Health Assessment completed by a Doctor / General Practitioner*
- ☐ Forensic history including any current legal issues (e.g. orders, upcoming court dates)

* These documents are mandatory if you are applying for a Community Recovery Village or Accommodation Unit.

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APPLICANT DETAILS

First name: **Surname:**

Preferred name: **Date of birth:** / /

Current address:

Suburb: **Postcode:**

Email: **Phone:**

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-binary

Do you identify as LGBTI: ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

Culturally and Linguistically Diverse: ☐ Yes ☐ No **Country of birth:**

Main language spoken: ☐ English ☐ Other: .....

Interpreter required: ☐ Yes ☐ No **Visa status:**

Marital status: ☐ Single ☐ De facto ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Children: ☐ Yes ☐ No

If applying for Bart's Plus Family Service, please answer these questions:

How many children do you have and their ages:

Are they attending school: ☐ Yes ☐ No **More information:**

Do they have any health issues: ☐ Yes ☐ No **More information:**

Do they require any support: ☐ Yes ☐ No **More information:**

Do you have primary custody: ☐ Yes ☐ No **Are there custody issues:** ☐ Yes ☐ No

Is the Department for Child Protection and Family Support [DCPFS] involved: ☐ Yes ☐ No

More information (including branch and name of Case Manager):

HOUSING

Have you stayed at St Bart's before: ☐ Yes ☐ No **If yes, when:**

Current living situation: ☐ Privately owned ☐ With friends ☐ Hospital ☐ Rental ☐ Supported ☐ Homeless ☐ With carer / family ☐ Hostel ☐ Other: .....

Are you on the Housing waitlist: ☐ Yes ☐ No **Are you priority listed:** ☐ Yes ☐ No

FINANCE

St Bart's

Source of income: ☐ Age Pension ☐ Youth Allowance ☐ Disability Support Pension ☐ Paid Work ☐ Newstart Allowance ☐ Other:

Do you currently have any outgoings? (e.g fines, child support etc):

Do you hold a Department of Veterans' Affairs [DVA] Health Card: ☐ Yes ☐ No

Centrelink Customer Reference Number [CRN]: **Expiry:**

Medicare number: **Expiry:**

CONTACTS

Next of Kin or nominated support person: **Relationship:**
Email: **Phone:**

Do you have a Clinical Case Manager: ☐ Yes ☐ No **Name:**
Email: **Phone:**

Do you have a Doctor / General Practitioner [GP]: ☐ Yes ☐ No **Name:**
Email: **Phone:**

Do you have a Psychiatrist: ☐ Yes ☐ No **Name:**
Email: **Phone:**

Do you have a Guardian: ☐ Yes ☐ No **Name:**
Email: **Phone:**

Do you have a Public Trustee: ☐ Yes ☐ No **Name:**
Email: **Phone:**

Do you have a Carer: ☐ Yes ☐ No **Name:**
Email: **Phone:**
Is this Carer a child or aged person: ☐ Child ☐ Aged person ☐ Other: .....

Do you have DCPFS Case Worker: ☐ Yes ☐ No **Name:**
Email: **Phone:**
Branch:

Do you have a Community Corrections Officer: ☐ Yes ☐ No **Name:**
Email: **Phone:**
Location:

Other Support Person/Service (e.g NDIS, Silverchain etc): **Name:**
Email:
Phone:

DISABILITY

St Bart's

Do you have a Disability: ☐ No ☐ Yes (please specify): .....

Do you have a current NDIS Plan: ☐ Yes ☐ No **If yes, please include a copy with this referral.**

Do you have any current support from a Disability service? (e.g Silverchain etc) ☐ Yes ☐ No
Details:

PHYSICAL HEALTH

Physical Health issues / conditions (tick all that apply)**:**

Diabetes	☐ Yes	☐ No	Falls risk	☐ Yes	☐ No
Heart complaint	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No	Bruise or bleed easily	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Skin conditions	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Stomach conditions	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No	Allergy (medically diagnosed) Anaphylatic	☐ Yes ☐ Yes	☐ No ☐ No
Hepatitis C	☐ Yes	☐ No	Medication allergy	☐ Yes	☐ No
Hepatitis D	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No	Acquired Brain Injury	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Thyroid problem	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No	Eating disorder	☐ Yes	☐ No
Visual impairment	☐ Yes	☐ No	Substance use	☐ Yes	☐ No
Hearing impairment	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Mobility impairment	☐ Yes	☐ No	Other:	☐ Yes	☐ No

If you ticked yes to any of the above, please provide details:

MENTAL HEALTH

Do you have a Mental Health Diagnosis: ☐ No ☐ Yes
If yes please specify (diagnosis, date of diagnosis etc)

Are you under the care of a Community Mental Health team or Psychiatrist: ☐ Yes ☐ No

MEDICATION

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Do you take regular prescribed medication: ☐ Yes ☐ No **Is it Webster packed:** ☐ Yes ☐ No

Do you require support taking your medication: ☐ Yes ☐ No

Are you on a Community Treatment Order [CTO]: ☐ Yes ☐ No

Any hospital admissions in the last 12 months: ☐ Yes ☐ No

If yes, please provide details:

DRUG AND ALCOHOL USE

Do you have a history or are you currently using drugs or alcohol: ☐ Yes ☐ No

If yes, please provide details of drug(s) of concern, frequency, amount, history of use:

Are you currently smoking tobacco: ☐ Yes ☐ No

If yes, please provide details of frequency and amount:

Are there any associated risk behaviours or problems (e.g. Hepatitis, injecting, overdose)**:** ☐ Yes ☐ No

If yes, please provide details:

Are you currently accessing support around your smoking, drug or alcohol use: ☐ Yes ☐ No

If yes, please provide details:

LEGAL/OFFENCES

Do you have any past or current legal issues (e.g community orders / pending court dates/prison history)**:** ☐ Yes ☐ No

If yes, please provide details:

To complete if applicant is being referred from prison:

Prison Location: **Time Length in Prison:**

Full Sentence date:

Are you applying for Parole: ☐ Yes ☐ No **if yes Parole date**:_____

Have you been assigned a Community Corrections officer: ☐ Yes ☐ No *if yes please provide details in 'Contacts' on page 3.*

SUPPORT NEEDS

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Are there any particular tasks you find challenging:

What support do you need (tick all that apply)**:**

☐ Toileting	☐ Gardening	☐ Medication
☐ Showering	☐ Transport	☐ Advocacy
☐ Dressing / undressing	☐ Shopping	☐ Accessing services
☐ Clothes washing	☐ Budgeting	☐ Attending appointments
☐ Cleaning	☐ Staying safe	☐ Engaging with social groups
☐ Cooking	☐ Communicating (reading / writing)	☐ Family relationships
☐ Eating	☐ Computer / IT skills	☐ Getting in/out of bed
☐ Other:_____		

Do you get support from other services: ☐ Yes ☐ No If yes, please include details under 'Contacts'.

OTHER

Additional comments:

☐ I **agree** that St Bart's may contact my health / community service providers to gather additional information to assist with my referral, if needed.

☐ I **consent** to my referral being submitted for consideration of the selected St Bart's Integrated Services.

Name: .....

Signature: ..... Date: ...../...../.....

If the applicant has a State appointed Guardian they must additionally sign:

Guardians Name: .....

Signature: ..... Date: ...../...../.....