REFERRAL FORM

PART A – For completion by client or client's representative (if applicable)

Consent to release of information (By guardian/case manager)

I ________________________________ consent for the information collected on the attached SRS Referral

Form to be released to the SRS Provider who will be providing accommodation and care to me.

Signed ___________________________________ Date ______________________

Representative Name _____________________

Representative Relationship___________________ Ph/Mb ______________________

Part B – For completion by referrer

Reason for referral to SRS

I ___________________________________ am familiar with the Green Haven S.R.S. and the Services it provides to residents. *Yes* □ *No* □

I consider that referral of this client to the SRS is appropriate because

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Signed ________________ Relationship____________ Date ______________________

Client

Surname ___________________________ Given Name ______________________

Preferred Name ___________________________ Gender M / F

Date of Birth ___________________________ Nationality ______________________

Language ___________________________ Religion ______________________

Pension Details

Medicare No ___________________________ Exp ______________________

Pension No ___________________________ Exp ______________________

Case Manager

Name ______________________ Organisation ______________

Telephone ______________________ Fax ______________

Address ______________________ Suburb ______________

Postcode ______________________

Guardian

Name ______________________ Organisation ______________

Telephone ______________________ Fax ______________

Address ______________________ Suburb ______________

Postcode ______________________

Financial Administrator

Name ______________________ Organisation ______________

Telephone ______________________ Fax ______________

Address ______________________ Suburb ______________

Postcode ______________________

Next of Kin

Name ______________________ Relationship ______________

Telephone ______________________ Fax ______________

Address ______________________ Suburb ______________

Postcode ______________________

Medical Practitioner

Name ______________________ Organisation ______________

Telephone ______________________ Fax ______________

Address ______________________ Suburb ______________

Postcode ______________________

Current Medication (*Please attach a copy of medication chart if possible)*

Drug Name / Dosage	B'fast	Lunch	Dinner	Bedtime

Can the client manage his/hre own medication? *Yes* □ *No* □

Does the client have the medication with her/ him? *Yes* □ *No* □

Physical Status

Are there any pre-existing medical conditions or allergies? *Yes* □ *No* □

Is the client's current health status expected to remain stable? *Yes* □ *No* □

Please provide details

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Cognitive Status

Are there cognitive issues to which SRS staff needs to be alerted? *Yes* □ *No* □

Oriented to time and place? *Yes* □ *No* □

Independent in organizing tasks/decision-making? *Yes* □ *No* □

Memory impaired? *Yes* □ *No* □

If others, please specify below:

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Mental Health Status

Are there mental health issues to which staff needs to be alerted? *Yes* □ *No* □

Please specify below:

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Behaviours

Tick any behaviors that may require special consideration.

Self harm	□	*Capacity to share*	□	*Capacity for co-operation*	□
Verbal Aggression	□	*Impulse control*	□	*Drug/alcohol use*	□
Physical Aggression	□	*Capacity to socialize*	□	*Self- motivation*	□
Wandering	□	*Abscond*	□	*Smoking*	□

If others, please specify below:

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Personal Care

	No Assistance	*Prompting/Supervision*	*Active Assistance*
Eating / drinking / diet	□	□	□
Showering / bathing	□	□	□
Dressing	□	□	□
Toileting	□	□	□
Mobility	□	□	□
Shaving/grooming	□	□	□
Dental Hygiene	□	□	□
Fingernails care	□	□	□

Aids and Appliances

Communication	*Glasses*	□	*Hearing Aids*	□	*Others*	□
Mobility	*Stick*	□	*Frame*	□	*Wheelchair*	□
Others	*Dentures*	□	*Bowel Incontinence*	□	*Breathing Problem*	□
	Diabetic	□	*Urinate Incontinence*	□	*Constipation*	□
	Heart Problem	□				

Others

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Community Living Skills

Is client able to access public transport? *Yes* □ *No* □

Is client able to make and keep appointments? *Yes* □ *No* □

Relevant health and community services

Does the resident currently access other community services? *Yes* □ *No* □

Organisation ________________ Contact Person ________________

Telephone ________________ Fax ________________

Address ________________ Suburb ________________

Postcode ________________

Other relevant information/ additional details

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