

# REFERRAL FORM

## ELTHAM VILLA

1120 MAIN ROAD

ELTHAM 3095

PHONE: 9431-3687

FAX: 9431-3698

Name of SRS

ELTHAM VILLA

PART A: for completion by client or client's representative (if applicable)

### CONSENT TO RELEASE OF INFORMATION

I,

(Name of person giving this consent)

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:

(Name of person being referred)

Signed: .....  
(Signature of person giving this consent)

Date

Representative name

Representative relationship

Phone

[Note: this consent is requested in order to comply with privacy legislation]

PART B: for completion by referrer

### REASON FOR REFERRAL TO RESERVOIR LODGE

I

am familiar with the above-named

SRS and the services it provides to residents.

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

Signed.....	Date	<input type="text"/>
Position	<input type="text"/>	Agency <input type="text"/>
	Phone	<input type="text"/>

Client Details		
Surname	<input type="text"/>	First name <input type="text"/>
Date of birth	<input type="text"/>	Gender M F
Language	<input type="text"/>	Religion <input type="text"/>
Current address	<input type="text"/>	
[If client is residing in another SRS]		
Name of SRS	<input type="text"/>	Phone <input type="text"/>
[If the client has private health insurance]		
Insurer	<input type="text"/>	Ref. Number <input type="text"/>

Next of Kin Details		
Name	<input type="text"/>	Relationship <input type="text"/>
Address	<input type="text"/>	
Phone	<input type="text"/>	

Medical Practitioner

Name

Phone

Address

[If the client has a guardian]

Name

Phone

Address

Client Ref.  
Number

[If the client has an administrator]

Name

Phone

Address

Client Ref.  
Number

Pension Details

Type of income

☐

Centrelink

☐

Veterans' Affairs

☐

Overseas Pension

Client Ref. Number

Medicare Number

Expiry date

Taxi Concession

Expiry date

Card Number

Medication. This information to be provided by client's health provider.

Drug name	Dose	Frequency	Duration	Last Taken

Does client have the medication with her/him? Y ☐ N ☐

Is the client able to administer own medication? Y ☐ N ☐

Please specify any anticipated side effects of medication:

Physical Status

Please list any pre-existing medical conditions or allergies.

Cognitive Status

Please list any cognitive issues to which SRS staff need to be alerted, e.g. orientation to time and place; independence in decision making; memory impairment; other.

Disability

[If the client is registered with Disability Services (DHS)]

Primary disability

Case Manager

Phone

Mental Health Status

Please specify any mental health issues to which staff need to be alerted.

[If the client is subject to a Community Treatment Order]

Case Manager

Phone

Behaviour

List any behaviour that may require special consideration

Self-harm

☐

Smoking

☐

Self-motivation

☐

Capacity for cooperation

☐

Physical aggression

☐

Wandering

☐

Capacity to share

☐

Capacity to socialise

☐

Verbal aggression

☐

Drug/alcohol

☐

Impulse control

☐

Other

☐

Details

List any known "triggers" for problem behaviour

Personal Care	No Assistance	Prompting/Supervision	Active Assistance
Eating/drinking/diet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Showering/bathing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Shaving/grooming	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Dressing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Dental hygiene	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Toileting	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Foot care/nail care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Laundry	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Housekeeping	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Aids and Appliances

Does client use any aids or appliances?

Mobility

Stick

☒

Frame

☒

Wheelchair

☒

Other

☒

Communication

Glasses

☐

Hearing Aid

☒

Interpreter

☒

Other

☐

Other

Dentures

☐

Continence aids

☒

Comments

Community Living Skills

Is the client able to access public transport?

☒ Yes

☐ No

Is the client able to make and keep appointments?

☐ Yes

☐ No

Recreation/Socialization

If the client attends any community based social activities, please provide details:

If the client has interests or hobbies, please provide details:

#### Relevant Health and Community Services

If the client has a case manager:

Name  Phone

Organisation

Address

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If the client currently accesses other services, please provide details:

Organisation

Contact Person  Phone

Address

Organisation

Contact Person  Phone

Address

If the client has been referred to additional services, please provide details:

Organisation

Contact  
Person

Phone

Organisation

Contact  
Person

Phone

Other relevant information/additional details

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.....

.....

Name

Position



Organisation

Signature:..... Date