The Reservoir Hub
Independent Living Units

REFERRAL FORM

THE RESERVOIR HUB INDEPENDENT LIVING UNITS – OFFICE 2, 15A TOVEY ST RESERVOIR 3073 E: thereservoirhub@mail.com P: 0407 545 357

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 Referral Form to be released to the accommodation provider who will be providing accommodation and care to:

_____
(Name of person being referred)

Signed:……. **Date** _____
(Signature of person giving this consent)

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 THE RESERVOIR HUB INDEPENDENT LIVING UNITS OFFICE 2, 15A TOVEY STREET RESERVOIR 3073

I _____ am familiar with the above-named accommodation and the services it provides to residents. www.dependablecare.net.au

I consider that referral of this client to The Hub Independent Living Units is appropriate because:

_____

Signed…….. **Date**

Position **Agency**

Phone

Client Details

Surname **First name**

Date of birth **Gender M F**

Language **Religion**

Current address

[If client is residing in another SRS/accommodation]

Name of SRS/ location **Phone**

Does the client have NDIS: Yes/No If yes NDIS Number:_____
Is plan attached? Yes/No

[If the client has private health insurance]

Insurer **Ref. Number**

Next of Kin Details

Name **Relationship**

Address

Phone

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 Card Number | **Expiry date**

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	☐	☐	☐
Mobility	☐	☐	☐
Showering/bathing	☐	☐	☐
Shaving/grooming	☐	☐	☐
Dressing	☐	☐	☐
Dental hygiene	☐	☐	☐
Toileting	☐	☐	☐
Foot care/nail care	☐	☐	☐
Laundry	☐	☐	☐
Housekeeping	☐	☐	☐

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

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

……

……

……

……

……

Name | **Position**

Organisation

Signature:…… **Date**