Acacia Gardens Supported Residential Services Referral Form

Your information is very important to us to provide the relevant care

Name of SRS: Acacia Gardens SRS

PART A:
(for completion by Client or Client's Representative (if applicable))

Consent to Release 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 if different from above)

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

Representative Name: _____

Representative Relationship: _____ Phone No: _____

(Note: this consent is requested in order to comply with Privacy Legislation)

PART B:
(for completion by Referrer)

Reason for Referral to SRS

I, _____
(Name of person giving this referral)

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: _____
(Signature of person giving this Referral)

Position: _____ Agency: _____ Phone No: _____

Address: 35 Mt Dandenong Road, Ringwood East VIC 3135 Tel: 03 9870 0982 Fax: Fax: 9870 1483
Email:acaciagardensringwood@gmail.com

Acacia Gardens Supported Residential Services Referral Form.

Client Details

Surname: First Name:

Date of Birth: Gender: Male Female

Language Spoken: Religion:

Current Address:

(If client is residing in another SRS)

Name of SRS: Phone No:

(If the client has Private Health Insurance)

Name of Insurer: Ref. No:

Next of Kin Details

Name: Relationship to Client:

Address:

Phone No:

Medical Practitioner Details

Name: Phone No:

Address:

Guardian Details (if Applicable)

Name: Phone No:

Address:

Client Reference No:

Administrator Details (if Applicable)

Name: Phone No:

Address:

Client Reference No:

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Pension Details

Type of Income:
- ☐ Centrelink
- ☐ Veteran's Affairs
- ☐ Overseas Pension
- ☐ Other (give details)

Client Reference No:

Medicare No: Expiry Date:

Taxi Concession Card No: Expiry Date:

Medication Details (This information to be provided by Client's Health Provider)

Drug Name:	Dose:	Frequency	Duration	Last Taken

Does the client have the medication with them? ☐ Yes ☐ No

Is the client able to administer their own medication? ☐ Yes ☐ No

Please specify any anticipated side effects of medication:

Physical Status

Please list any pre-existing medical condition or allergies.

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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; etc.

Disability Details (If the client is registered with Disability Services (DHS))

Primary Disability:

Case Manager: Phone No:

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 No:

Behaviour

Select any behaviour that may require special consideration

☐ Self-harm	☐ Impulse control	☐ Capacity to share	☐ Capacity for cooperation
☐ Wandering	☐ Drug/alcohol	☐ Physical aggression	☐ Capacity to socialise
☐ Smoking	☐ Self-Motivation	☐ Verbal aggression	☐ Other

Details

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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 the client use any aids or appliances? ☐ Yes ☐ No

Mobility - ☐ Stick ☐ Frame ☐ Wheelchair ☐ Other

Communication- ☐ Glasses ☐ Hearing Aid ☐ Interpreter ☐ Other

Other ☐ Dentures ☐ Continence aids

Comments

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Community Living Skills

Is the client able to access public transport? ☐ Yes ☐ No

Is the client able to make and keep appointment? ☐ Yes ☐ No

Recreation / Socialisation

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

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

Relevant Health and Community Services

If the client has a Case Manager.

Case Manager's Name: Phone No:

Organisation:

Address:

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

Organisation:

Contact Person: Phone No:

Address:

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

Organisation:

Contact Person: Phone No:

Organisation:

Contact Person: Phone No:

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Other Relevant Information / Additional Details

Name: Position:

Organisation:

Signature: Date:

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