

DAREBIN LODGE REFERRAL FORM

Part A: for completion by prospective client or client's representative

CONSENT TO RELEASE INFORMATION	
I, consent to 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.	
<u>Signed:</u>	<u>Date:</u>
<u>Representative name:</u>	
<u>Representative relationship:</u>	<u>Telephone:</u>
(Note: this consent is requested in order to comply with privacy legislation).	

PART B: for completion by referrer

REASON FOR REFERRAL TO SRS	
I consider that the referral of this client to Darebin Lodge is appropriate because	
<u>Signed:</u>	<u>Date:</u>
<u>Agency:</u>	<u>Position:</u>

:

Client details	
<u>Surname:</u>	<u>First name:</u>
<u>Current address:</u>	
	<u>Postcode:</u>
<u>Date of birth:</u>	<u>Telephone:</u>
<u>Language spoken:</u>	<u>Religion:</u>
<u>Likes/Interest/Hobbies:</u>	
<u>Dislikes:</u>	
<u>Fears and Phobias:</u>	

Next of kin details	
<u>Name:</u>	<u>Relationship:</u>
<u>Address:</u>	
<u>Telephone:</u>	

Medical Practitioner	
<u>Name:</u>	
<u>Telephone:</u>	
<u>Address:</u>	
Does your Doctor do home visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who will be responsible for taking you to your appointments? (including hospital appointments)	
Alternatively, do you wish to visit one of the doctors who located very close to Darebin Lodge? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide a medication list/treatment sheet signed by the doctor which will then allow an easy transition to our regular pharmacy.
Please note that while you are at Darebin Lodge all your medication will be kept under lock and key and will be administered by staff.

Does the client have a Guardian (please give details) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the client have a financial administrator (please give details) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pension Details	
<u>Type of pension:</u>	
Do you receive any other allowances from Centrelink? (please specify)	
<u>Client Reference No:</u>	
Do you have a taxi concession card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Medicare Number:</u>	<u>Expiry date:</u>

Physical Status	
Are there any pre-existing conditions or allergies? (If yes, please give details) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Cognitive Status	
Are there any cognitive issues to which SRS staff need to be alerted to? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Orientated to time and place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Independent in decision-making and organizing tasks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Memory unimpaired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered yes to any of the above questions, please provide details.	

Disability/Mental Health Status			
What is the primary disability?			
Are there any mental health issues to which staff need to be alerted to? If yes, please give details	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Is the client on a Community Treatment Order?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Details of case manager/support worker?			
Does the client currently access other health and community services. (if yes, please provide details)	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Behaviour			
List any behaviour that may require special consideration			
Self harm <input type="checkbox"/>	Smoking <input type="checkbox"/>	Self-motivation <input type="checkbox"/>	
Physical aggression <input type="checkbox"/>	Verbal aggression <input type="checkbox"/>	Wandering <input type="checkbox"/>	
Drug/alcohol use <input type="checkbox"/>	Impulse control <input type="checkbox"/>	Capacity to share <input type="checkbox"/>	
Capacity for cooperation <input type="checkbox"/>	Capacity to socialize <input type="checkbox"/>	Other <input type="checkbox"/>	
Please provide details:			

Personal Care	No Assistance	Prompting/ Supervision	Active Assistance
Eating/drinking			
Mobility			
Showering			
Shaving/grooming			
Dressing			
Dental hygiene			
Toileting			
Foot care/nail care			

Aids and Appliances
Does the client use any aids or appliances? (examples: glasses, hearing aids, walking frame, walking stick, dentures, continence aids etc)
Who is responsible for the cost of providing these aids if no funding is available?

Other relevant information/additional details
<u>Name:</u> _____ <u>Position:</u> _____
<u>Organisation:</u> _____ <u>Signature:</u> _____