|  |  |
| --- | --- |
| **Name of SRS:** | **Murphy House – 5-7 Murphy Street, Kennington** |

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| **PART A: for completion by Participant or Participant’s Representative** |
| Consent to Release Information |
|  |
| I,  |  |  |
|  | (Name of person giving this consent) |
| Consent for the information collected on this SRS Referral Form to be released to the SRS provider who will be providing accommodation and care to: |
| Name: |  |  |
|  | (Name of person being referred if different from above) |
| Signed: |  | Date: |  |  |
|  | (Signature of person giving this consent) |
| Representative Name: |  |  |
|  |  |  |
| Representative Relationship: |  | Phone No: |  |  |
|  |  |  |  |

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| **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 participants. I consider that referral of this participant to the SRS is appropriate because: |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |
| Signed: |  | Date: |  |  |
|  | (Signature of person giving this referral) |
| Representative Name: |  |  |
|  |  |  |
| Position: |  | Agency: |  | Phone No: |  |  |
|  |  |  |  |

|  |
| --- |
| **Participant Details** |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Date of Birth: |  | Gender |  | Male |  | Female |  | Non-binary |  |
|  |  |  |  |  |
| Religion: |  | Language: |  |  |
|  |  |  |  |  |
| Current |  |  |
| Address: |  |  |
|  |  |  |
|  | If Participant is residing in another SRS |  |  |
| Name of SRS: |  |  | Phone No: |  |  |
|  | If the Participant has Private Health Insurance |  |  |  |  |
| Insurer: |  |  | Ref No: |  |  |
|  |  |  |  |  |  |

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| **Next of Kin Details** |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Relationship: |  | Phone: |  |  |
|  |  |  |  |  |
| Address: |  |  |
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| **Medical Practitioner Details** |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Address: |  |  |
|  |  |  |
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| **Guardian Details (If Applicable)** |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Ref No: |  |  |  |
|  |  |  |  |  |
| Address: |  |  |
|  |  |  |
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| **Administrator Details (If Applicable)** |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Phone: |  |  |  |
|  |  |  |  |  |
| Address: |  |  |
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| **Pension Details** |
|  |
| Type of Income: |  | Centerlink |  | Veteran’s Affairs |  |
|  |  |  |  |  |  |
|  |  | Overseas Pension |  | Other (Give details) |  |  |
|  |  |  |  |  |
| Ref No: |  | Medicare No: |  |  |
|  |  |  |  |  |
| Taxi Conc No: |  | Expiry Date: |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Medication Details (this information is to be provided by the Participant’s Medical Practitioner)** |
|  |
|  | Drug Name: | Dose: | Frequency: | Duration: | Last Taken: |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |
|  | Does the Participant have the medication with them? |  | Yes |  | No |  |
|  |  |  |  |  |  |  |  |
|  | Is the Participant able to administer their own medication? |  | Yes |  | No |  |
|  |  |  |  |  |  |  |
|  | Please specify any anticipated side effects of medication.  |  |  |  |  |  |
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| **Physical Status** |
|  | Please list any pre-existing medical conditions 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.  |
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| **Mental Health Status** |
|  | Please specify any mental health issues to which staff need to be alerted.  |
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|  |  |  |
|  | (If the Participant is subject to a Community Treatment Order) |
|  |  |
|  | Case Manager: |  | Phone: |  |  |
|  |  |  |  |  |  |  |  |

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| **Disability** |
|  |
| Disability: |  | Psychosocial |  | Intellectual |  | Mental Health |  | Autism |  | Physical |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Other  |  |  |
|  |  |  |  |  |
| NDIS No: |  | Support Coordinator |  | Phone: |  |  |
|  |  |  |  |  |  |
| NDIS Plan | Start Date |  | End Date |  | Plan Included? |  | Yes |  | No |
|  |  |  |  |  |  |
| Billing Details |  | NDIA |  | Third Party |  | Self-Managed |  |
|

|  |  |
| --- | --- |
| Third Party Name |  |

|  |  |
| --- | --- |
| Third Party Email |  |

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| **Behaviour** |
| **Select any behaviour that may require special consideration.**  |
|  |
|  |  | Self-harm |  | Impulse Control |  | Capacity to cooperate |  | Capacity to share |
|  |  |  |  |  |  |  |  |  |
|  |  | Wandering |  | Drug/Alcohol |  | Physical aggression |  | Capacity to socialise |
|  |  |  |  |  |  |  |  |  |
|  |  | Self-motivation |  | Smoking |  | Verbal aggression |  | Other |
|  |
| **Details** |
|  |  |  |
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|  |  |  |
|  | **List any known ‘Triggers’ for behaviours of concern.**  |  |
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|  |  |  |
|  |  |  |
|  | Behavioural Support Plan in place? |  | Yes |  | No |  |  |
|  |  |  |  |  |
|  | Practitioner Name: |  | Phone: |  |  |
|  |  |  |  |  |  |

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| **Personal Care** |
|  | No Assistance | Prompting/Supervision | Active Assistance |
| Eating/Drinking/Diet | ☐ | ☐ | ☐ |
| Mobility | ☐ | ☐ | ☐ |
| Showering/Bathing | ☐ | ☐ | ☐ |
| Shaving/Grooming | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ |
| Dental Hygiene | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ |
| Foot Care/Nail Care | ☐ | ☐ | ☐ |
| Housekeeping | ☐ | ☐ | ☐ |

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| **Aids and Appliances** |
|  |  |  |  |  |
| Does the Participant 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 Participant able to access public transport? |  | Yes |  | No |
|  |
| Is the Participant able to make and keep appointments |  | Yes |  | No |
|  |  |  |

|  |
| --- |
| **Recreation and Socialisation** |
|  |
|  | **List any community-based activities the Participant attends.** |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **List any hobbies or special interest the Participant may have.**  |  |
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| **Health and Community Services** |
| If the Participant has a Case Manager |
|  |
| Surname: |  | First Name: |  |  |
|  |  |  |  |  |
| Organisation: |  |  |
|  |  |  |  |  |
| Address: |  |  |
|  |  |  |
| If the Participant currently accesses other services, please provide details: |  |  |  |  |
|  |  |  |  |  |  |
| Organisation: |  |  |
|  |  |  |  |  |
| Contact: |  |  | Phone: |  |  |
|  |  |  |  |  |
| Address: |  |  |
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| **Other Relevant Information** |
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|  |  |  |  |  |  |
|  | Name: |  | Position: |  |  |
|  |  |
|  | Organisation: |  | Date: |  |  |
|  |
|  | Signature: |  |  |
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|  |  |