Berwick House Supported Residential Service

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SRS Referral Form

PART: A To be completed by a client or client's **representative** (if applicable)

Consent to release information

I .....consent for the information collected on the attached SRS Referral form to be released to the SRS Provider who will be providing accommodation and support for me.

Signed:.....**Date:**.....

Representative name: .....

Representative's relationship to the client.....Contact No.....

PART: B To be completed by a referrer

Reason for referral to the SRS

I.....am familiar with the SRS and the service it provides to residents **YES/No**

I consider the referral for this client to the SRS is appropriate because

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Signed:.....**Date:**.....

Position:.....**Agency:**.....

Client's details

Surname:.....Name:.....

Date of Birth:.....

Current Address: .....
.....
.....

Language spoken:.....

Gender: Male/Female (Circle)

Religion:.....

Medicare Number: .....

Mobile (if applicable): .....

Does the client have private insurance Yes/No

Insurer: ..... Reference Number: .....

Reason for leaving from current accommodation:
.....

.....

If the client is residing in a SRS

Name of the facility:.....

Address: .....
.....
Contact No.....

Manager: .....

Reason for leaving: .....

.....

Next of Kin Details

Name: .....**Relationship:**.....

Address:.....
.....
.....

Contact Number: .....

Is your next of kin same as your person nominated? If NOT, please provide person nominated contact details below.

Name: .....**Relationship:**.....

Address:.....
.....
.....

Contact Number: .....

Medical Practitioner

Name: .....

Address:.....
.....
.....

Contact No. .....

Does the client have a guardian Yes/No (circle)

Name: .....
Address:.....
.....
.....
Contact No. .....
Reference No.: .....

Pension Details (circle the applicable one)

Type of income: Centrelink/ Veteran Affairs/Overseas Pension

Client Reference Number: .....Expiry date:.....

Tax Concession Card Number: .....Expiry date: .....

Medication

Please note: this information is to be provided by the client's medical practitioner

Drug name	Dose	Frequency	Duration	Last taken

Does the client have medication with him/her? **Yes/No**

Is the client able to administer own medication? **Yes/No**

if yes it has to be safely secured locked away.

Please specify any anticipated side effects or allergies of medication

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Physical Status

Are there any pre-existing medical conditions or allergies? **Yes/No**

Is the client's current health status expected to remain stable? **Yes/ No**

If yes to the above please provide information

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Cognitive Status

Are there any cognitive issues to which SRS staff needs to be alerted of? **Yes/No**

Oriented to time and place? **Yes/No**

Memory unimpaired? **Yes/No**

Independent in decision- making and organising tasks? **Yes/No**

Disability

Is the client registered with the DHS Disability Client Services? **Yes/No**

What is the primary disability? **.....**

Name of the case manager**: .....**

Address: .....

Contact No. .....

Name of the Phychiatrist: .....

Address: .....

.....

Contact No. .....

Behaviour

List of behaviours that may require special consideration (please circle the one appropriate)

Self harm	Smoking	Self motivation	Capacity for cooperation
Physical aggression	Verbal aggression	Wandering	Capacity to share
Capacity to socialize	Drug/Alcohol abuse	Impulse Control	
Arsonist	Other		

Details .....
.....
.....

Support Care

Does the resident need support care with the following:

	No Assistance/	**Prompting/**	**Supervision/**	**Active Assistance**
Eating/ drinking/diet/	☐	☐	☐	☐
Mobility	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Foot Care/ Nail Care	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Dental Hygiene	☐	☐	☐	☐

Diabetes

Is the client diabetic? **Yes/No**

If yes is the client only on medication or on insulin? **Yes/No**

If on insulin is the client administering insulin or agency has been organised? **Yes/No**

More details required: .....

.....

Aids and appliances

Does the 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

What are the client's interests/ hobbies?

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Relevant Health and Community Services

Does the client have a case manager? **Yes/No**

Name: .....

Address: .....

Contact No: .....

Does the client Currently access other services? **Yes/No**

1. Organisation: .....

Contact Person/phone No.: .....

2. Organisation: .....

Contact Person: .....

Address: .....

Contact No. .....

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

Organisation: .....

Contact Person: .....

Contact No. .....

Address: .....

Other relevant information/Additional details

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.....

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Name: .....

Position: .....

Organisation: .....

Signature: .....Date: .....