QUEENS LODGE SRS – REFERRAL FORM

5 Queens Street Lalor. VIC. 3075

Phone: 03 94650053 **Email: queenslodgeoffice@gmail.com**

CONSENT TO RELEASE INFORMATION – Completed by client (option 1) or representative (option 2)

Option 1:

I, …… consent for the information collected on the
[Name of person giving this consent]
attached SRS Referral Form to be released to (xxx) SRS and for the SRS proprietor to contact the services listed in this form regarding my support needs.

Signed …… Date ……..

Option 2:

As a formal representative, I ……., on behalf of, ……
(Name of representative) (Client's name)
consent for the information collected on the attached SRS Referral Form to be released to (xxx) SRS and for the SRS proprietor to contact the services listed in this form regarding their support needs.

Signed …… Date ……..

Representative Name……

Representative Relationship …… Ph.……
[Note: This is requested in order to comply with privacy legislation]

REASON FOR REFERRAL TO SRS – Completed by referrer

I,…… am familiar with (XXX) SRS and the services it provides to residents. I consider that the referral of this client to the SRS is appropriate because:

……

……

……

……

Signed …… Date……

Position …… Agency ……..

Ph/Mob: …… Email: ……

Supervisor/ Team Leader contact details (if applicable)

Name: …… Ph/Mob: ……..

Email: ……..

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CONTACT FOR INFORMATION

The following pages request some detailed information about the client's health and care needs. If you are unable to provide this information, can you suggest someone who may?

Name……

Address……

Telephone……

Relationship……

CLIENT DETAILS

First Name: …… Surname: ……

Preferred Name: …… Date of Birth: ……

Gender: Male/ Female/ Other …….. Language spoken: ……

Country of Birth: …….. Marital Status: ……

Aboriginal ( ) Yes ( ) No Torres Strait Islander ( ) Yes ( ) No ( ) Both
If yes, are they linked to any Aboriginal services? ( ) Yes or ( ) No
If yes, Please provide details
Organisation _____ Contact Person _____
Address _____
Ph/Mobile_____ Email_____
If No, would they like to be linked with Aboriginal services? ( ) Yes or ( ) No

Current/ Previous Address: ……

[If client is residing in another SRS]

Name of SRS: …… Phone: ……

Type of Income: ☐ Centrelink ☐ Veterans' affairs ☐ Overseas Pension
Type of Pension: ☐ Disability Support Pension ☐ Age Pension ☐ New allowance

Client Ref. Number: …….. Expiry Date: ……..

Medicare Number: …….. Expiry Date: ……

Taxi Concession Card No.: …….. Expiry Date: ……

Next of Kin Details

Name: …… Relationship to client: ……

Address: …….. Ph/Mobile: ……

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Medical Practitioner:

Name: …….. Clinic: …….. Ph: …….

Add: ……

Administrator:

Name: ……. Ph: ……

Add: …… Client Ref. Number: ……..

If the client has a Guardian:

Name: ……. Ph: ……

Add: ……

Diagnosis: ……..

……

CURRENT MEDICATION – Information to be provided by medical practitioner or attach a list of medications

Drug name	Dose	Frequency	Duration	Last taken

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

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

Please specify any anticipated side effects of medication

……

……

……

PHYSICAL STATUS

Please list any pre-existing medical conditions or allergies

☐ Diabetes ☐ Cardiovascular Disease ☐ Epilepsy

☐ Asthma ☐ Lung Disease ☐ Kidney Disease
☐ Incontinence ☐ Smoker ☐ Allergies
☐ Other

……
……

COGNITIVE STATUS

Are there any cognitive issues to which SRS staffs need to be alerted? ☐ Yes ☐ No

Independent in decision-making and organising tasks? ☐ Yes ☐ No

Memory impairment ☐ Yes ☐ No

Can the person read and write ☐ Yes ☐ No

Other: ……
……
……

DISABILITY

☐ ABI ☐ Intellectual Disability ☐ Dual Disability ☐ Physical Disability

Other: ……

MENTAL HEALTH STATUS

Are there any mental health issues to which staffs need to be alerted? ☐ Yes ☐ No

Please specify: ……

……

Is there any Community Treatment Order in place? ☐ Yes ☐ No

BEHAVIOURS

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

Please specify: ……

……

Please list any known “triggers” for problem behaviour and strategies that have worked previously

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PERSONAL CARE	No Assistance	prompting/supervision	Active assistance
Eating/drinking/diet			
Mobility			
Showering/bathing			
Shaving/grooming			
Dressing			
Toileting			
Foot/ Nail care			
Dental hygiene			
Laundry/ Housekeeping			

AIDS AND APPLIANCES

Does the client use any aids or appliances? ☐ Yes ☐ No
If yes, please specify:

Mobility

☐ Stick ☐ Frame ☐ Wheelchair ☐ Other

Communication

☐ Glasses ☐ Hearing aid ☐ Interpreter ☐Other

Other

☐ Dentures ☐ Continence aids

Comments: ……

……

COMMUNITY LIVING SKILLS

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

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

Recreation/socialisation

Is the client attending any community based social activities? ☐ Yes ☐ No
If yes, please provide details:

……

……

If no, would the client be interested in joining any social activities? ☐ Yes ☐ No

Please provide details of any interests and hobbies the client may have:

……

……

RELEVANT HEALTH AND COMMUNITY SERVICES

Is the client linked with Mental Health Services? ☐ Yes ☐ No

If yes, please provide details:

Service Name: ……Contact Person……

Address: …… Ph: ……..

If the client has NDIS support coordinator or other support services.

1. Organisation: ……...Contact Person……

Address ……Ph: ……

NIDS Reference Number: ……..

2. Organisation: ……...Contact Person……

Address ……Ph: ……

Has the client been referred to additional services? ☐ Yes ☐ No

If yes, please provide details:

1. Service Name: ……Contact Person……

Address: …… Ph: ……..

2. Service Name: ……Contact Person……

Address: …… Ph: ……..

Other relevant information/additional details

……

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……

THIS SECTION MUST BE SIGNED

- Have you ever been convicted or released on parole for criminal misconduct involving violence?

  ☐ Yes ☐ No

- Have you ever been convicted or released on parole for criminal misconduct involving stalking?

  ☐ Yes ☐ No

- Have you ever been convicted or released on parole for criminal misconduct involving sex offences?

  ☐ Yes ☐ No

- Are you or have you ever been listed on the Victorian Register of Sex Offenders, or equivalent in another State or Territory?

  ☐ Yes ☐ No

☐*I confirm that the information I have provided in this section is true and correct.*

☐*I understand that this document is a legal binding document and it is a criminal offence to provide false information.*

Resident name:	
Resident signature:	
Referrer's name and title:	
Referrer's signature:	
Date:	

Please tick if these have been provided (mandatory):

☐Summary of charges and/or convictions (including any current outstanding charges)

☐Copy of any current bail conditions and/or orders

Information gathered in this document will be kept confidential and will ONLY be used to assist with service provision that will be provided to the applicant.