SALISBURY HOME

Community Care Facility
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REFERRAL FORM

Personal details (affix label)

Name: _____ DOB: _____

Address: _____

_____

Tel: _____

Current location: _____

Preferred language: _____

Ethnicity: _____

Marital status: _____

Diagnosis: _____

Other disability (physical, intellectual, learning): _____

_____

Allergies: _____

Next of kin / significant other:

Name: _____

Address: _____

Tel: _____

Relationship to client: _____

Medicare number: _____ Expiry date: _____

Pension number and type: _____

Public Trust: Y / N TM: _____

Guardianship: Y / N Guardian: _____

CTO: Y / N

Referral Details

Referred by: _____

Case manager: _____ Date referred: _____

Telephone: _____ Location: _____

Proposed hostel(s): _____

Accommodation history

Independent community Y / N _____

Supported Y / N _____

Hostel Y / N _____

Reason for leaving previous accommodation: _____

_____

Reason for hostel placement: _____

_____

_____

Mental Health History

Current diagnosis: _____

Present stability of mental state: _____

Current suicide risk: _____

Approximate date of onset: _____

Number of admissions: _____

Date of most recent admission: _____

Duration and severity: _____

Family mental health history:

_____

_____

_____

_____

Current medications:

Comment on compliance:

Relapse indicators:

Risk issues

History of alcohol or other substance abuse	Y / N
History of self harm	Y / N
History/Risk of harm to others	Y / N
Risk of harm from others	Y / N
Forensic history	Y / N
History of antisocial / aggressive behaviour	Y / N
History of sexual vulnerability	Y / N
Pending legal proceedings	Y / N
Fire risk	Y / N

If yes please comment:

Management issues / behavioural challenges:

Social history

Describe social network (including location):

Describe relevant family / developmental factors:

OT / Rehabilitation

Interests / hobbies:

History of participation in OT / rehabilitation activities:

Other agencies / services involved (include previous interventions and outcomes):

Care Needs

Independently ambulant Y / N

Unsteady gait / history of falls Y / N

(Please give details of any assistive devices required)

_____

_____

_____

Continent (faecal and urinary) Y / N

Require pads Y / N

(If yes, who is paying for pads, and will this arrangement continue)

_____

_____

If the client cannot perform the following activities independently, please advise of level of assistance required.

- ☐ Meals and drinks _____
- ☐ Showering / washing _____
- ☐ Grooming _____
- ☐ Brushing teeth _____
- ☐ Toileting _____
- ☐ Cleaning of personal living space _____
- ☐ Care / safety of personal possessions _____

Please comment if client is likely to display any challenging behaviours during the performance of these activities (and current management):

_____

_____

_____

_____

Communication

Does the client have a speech / hearing / visual impairment that affects communication Y / N

Does the client communicate in English Y / N

Is the client competent in literacy Y / N

Is the client competent in numeracy Y / N

Community Access

Does the client know how to use public transport Y / N

Does the client drive a car Y / N

Does the client use taxi's Y / N

Does the client prefer to walk Y / N

Is assistance required with any of the above? Y / N

Is a lack of appropriate transport a barrier community access? Y / N

Finance

Is the client independent in financial management Y / N

Are finances managed by family or Public Trust Y / N

Is the client able to correctly make purchases Y / N

Current discharge / management plan:

Please include any relevant reports / documentation.