Acland Grange Supported Residential Service ABN: 51 672 867 259

166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

PROCESS FOR RESIDING at Acland Grange SRS

1. Make contact with Acland Grange SRS

▼

2. Arrange a visit

Come and have a look and ask questions, speak to other residents and staff members. This is an opportunity for you to see if Acland Grange SRS is the right accommodation option for you.

▼

*3. Complete a referral form**

If you like the facility and feel that it is the right accommodation option for you - fill in a referral form or have someone fill it in on your behalf.

* This must be completed before you can be offered a vacancy or be placed on our waiting list**.**

▼

4. Send in your completed referral form via:

Post, hand-delivery, or email.

▼

5. Your application is processed!

Your completed referral will be assessed and you will be notified within 24 hours of any suitable vacancy.

If you wish to take up the vacancy, a date and time for admission will be confirmed with you.

Acland Grange Supported Residential Service ABN: 51 672 867 259

166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

PART A: For Completion by client or client's representative (if applicable).

CONSENT TO RELEASE OF 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 care for me.

Signed: ..... Date: __/__/____

Representative name: ..... Telephone: (03) ____ ____

Representative relationship: ..... Mobile: 04__ ___ ___

[Note: this consent is requested in order to comply with privacy legislation]

Part B: For Completion by referrer.

REASON FOR REFERRAL TO SRS.

I..... am familiar with the..... SRS and the service it provides to the residents. ☐ Yes ☐ No.

I consider that referral of this client to the SRS is appropriate because: .....

.....

.

Signed: ..... Date: __/__/____

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

Client Details.

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

Current Address: ..... Suburb: ..... Postcode: .....

Date of Birth: __/__/____ Gender: ☐ Male ☐ Female.

Language Spoken: ..... Religion: .....

Country of Birth: .....

Does Your Client Identify as Aboriginal/Torres Strait Islander? ☐ Yes ☐ No. If Yes Circle the Option.

[If Client is residing in another SRS]

Name of Facility: ..... Telephone No. of SRS: (03)_____

Does the client have Private Health Insurance: ☐ Yes ☐ No.

Insurer: ..... Reference No. _____

Acland Grange Supported Residential Service ABN: 51 672 867 259

166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

Next of Kin Details.

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

Adress: ..... Suburb:
.....

Postcode: .....

Medical Practioner.

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

Adress: ..... Suburb:
.....

Postcode: .....

Does the client have a Guardian ☐ Yes ☐ No / An Administrator ☐ Yes ☐ No

Name: ..... Telephone:
.....

Adress: ..... Suburb:
.....

Postcode: ..... Client Reference No:
.....

Pension Details.

Type of income: ☐ Centrelink ☐ Veterans' Affairs ☐ Overseas Pension

Client Reference No: ..... Expiry Date:
.....

Medicare No: ..... Expiry Date:
.....

Taxi Concession No: ..... Expiry Date: .....

Medication.

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

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

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

Please Attach Client's Drug Chart.

Please specify any anticipated side effects of medication:

.....

ABN: 51 672 867 259

166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

Physical Status.

Are there pre-existing medical conditions or allergies? ☐Yes ☐No

Is the client health status expected to remain stable? ☐Yes ☐No

If yes to the above/ please provide details:
……

……
.

Weight: …… Kg.

Cognitive Status.

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

Oriented to time and place? ☐Yes ☐No

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

Memory unimpaired? ☐Yes ☐No

Other information please provide details:
……

……
.

Disability.

Is the client registered with Disability Services (DHS) or (NDIS) or Home Care Package? ☐Yes ☐No
What is the primary disability?
……..

Name of Case Manager: …… Telephone No: ……

Mental Health Status.

Are there Mental health issues to which SRS staff need to be alerted? ☐Yes ☐No

If yes, please specify:
……..……

Is the client on a Community Treatment Order? ☐Yes ☐No

Name of Case Manager/Support Worker: …… Telephone No: ……

Behaviour.

List any behaviour that may require special consideration:

Other Details:
……

ABN: 51 672 867 259
166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

Aids and Appliances.

Does the client use any aids or appliances?

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 and Socialisation.

What are the client's interest and hobbies? .....

.....

ABN: 51 672 867 259

166-168 Barkly Street
ST. KILDA 3182
Phone: (03) 9525 3922
Proprietor: Li Xiao's Mobile: 0413 125 167
E-Mail: aclandgrangeli@gmail.com

Referral Form.

Relevant Health and Community Services.

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

Name: …… **Organisation:**
……

Address: …… **Suburb:**
……

Postcode: …… **Telephone:** ……

Does the client have access to any other services? ☐ **Yes** ☐ **No**

1st Organisation: …… **Contact Person:**
……

Address: …… **Suburb:**
……

Post Code: …… **Telephone:** ……

2nd Organisation: …… **Contact Person:** ……

Address: …… **Suburb:**
……

Post Code: …… **Telephone:** ……

Has referral been made to additional service? ☐ **Yes** ☐ **No**

1st Organisation: …… **Contact Person:**
……

Address: …… **Suburb:**
……

Post Code: …… **Telephone:** ……

2nd Organisation: …… **Contact Person:**
……

Address: …… **Suburb:**
……

Post Code: …… **Telephone:** ……

Other relevant information/additional details:
……

……
…

……
.

……
.

Name: …… **Position:**
……

Organisation: ……

Signature: …… **Date:**
……