Manalin House *Supported Residential Services*
ABN:55 648 508 347
18 Viney Street, Clarinda Vic. 3169
Office Ph: (03) 9551 7615
Ph: (03) 9512 7250
M:0426247631
Email: manalinhouse2022@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 to me.

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

Representative name.....

Representative relationship..... **Telephone**.....

[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 services it provides to 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**

Languages spoken..... **Religion**.....

[If client is residing in another SRS]

Name of facility..... **Telephone no. of SRS**.....

Does the client have Private Health Insurance? ☐**Yes** ☐ **No**
Insurer ..... **Reference No.**.....

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Referral Form

Next of Kin Details

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

Address..... **Suburb**.....

Postcode..... **Telephone**.....

Medical Practitioner

Name..... **Telephone**.....

Address..... **Suburb**.....

Postcode.....

Does the client have a Guardian ☐**Yes** ☐**No /** an Administrator ☐**Yes** ☐**No**?

Name..... **Telephone**.....

Address..... **Suburb**.....

Postcode..... **Client Reference no.** .....

Pension Details

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

Client Reference no. ..... **Expiry date**.....

Medicare Number..... **Expiry date**.....

Taxi Concession Card Number..... **Expiry date**.....

Medication

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

Drug name	Dose	Frequency	Duration	Last Taken

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

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

Please specify any anticipated side effects of medication.....

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Physical Status

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

Is client's current 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 staff need to be alerted? ☐**Yes** ☐**No**

Please specify……

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

Name of Case Manager/Support worker…… **Telephone no.**……

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Behaviour

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	☐

Details.....

.....

Personal Care	**No Assistance**	**Prompting/ Supervision**	**Active Assistance**
Eating/drinking/diet	☐	☐	☐
Mobility	☐	☐	☐
Showering/bathing	☐	☐	☐
Shaving/grooming	☐	☐	☐
Dressing	☐	☐	☐
Dental hygiene	☐	☐	☐
Toileting	☐	☐	☐
Foot care/nail care	☐	☐	☐

Aids and Appliances

Does 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 client able to access public transport? ☐**Yes** ☐**No**

Is client able to make and keep appointments? ☐**Yes** ☐**No**

Recreation/Socialization

What are the client's interests/hobbies?.....

.....

Relevant Health and Community Services

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

Name..... **Organisation** .....

Address..... **Suburb**.....

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Postcode..... **Telephone**.....

Does the client currently access other services? ☐**Yes** ☐**No**

1. **Organisation** ..... **Contact Person**.....

Address..... **Suburb**.....

Postcode..... **Telephone**.....

2. **Organisation** ..... **Contact Person**.....

Address..... **Suburb**.....

Postcode..... **Telephone**.....

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

1. **Organisation** ..... **Contact Person**.....

Address..... **Suburb**.....

Postcode..... **Telephone**.....

Referral Date..... **Expected Start Date**.....

2. **Organisation** ..... **Contact Person**.....

Address..... **Suburb**.....

Postcode..... **Telephone**.....

Referral Date..... **Expected Start Date**.....

Other relevant information/additional details

.....

.....

.....

.....

Name..... **Position**.....

Organisation..... **Signature**.....

Date.....