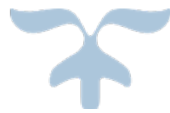
BURSWOOD CARE RESIDENT REFERRAL FORM



DATE OF REFERRAL: ………………

ADVICE TO REFERRING AGENCIES

REFERRAL PROCEDURE

Pre-admission

It is preferable that potential Residents view the Hostel, before referral forms are submitted, so that that they are confident in their decision to reside at this particular Hostel. A final decision cannot be made unless this process is followed and the Resident is happy with their choice.

Referral Form

The Hostel Referral Form as follows, *must be completed in full* prior to the applicant being admitted for the initial trial period. New Residents will not be admitted and assessment of the information will not occur before all relevant information is obtained from the Referral Agency. This requirement is mandatory and ensures as much as possible, that the delivery of care is seamless, the care is adequately planned and delivered and Resident and Staff safety is optimised.

Additional required documentation for admission.

Apart from the completed Referral Form, other documentation is required if applicable:

- A copy of the Discharge Summary if leaving Hospital e.g. mental and physical diagnoses; any infectious diseases; reason for admission; treatment provided; current medications and discharge plan;
- A current mental health assessment and plan;
- A current risk assessment, outlining current and past risks;
- The name of the current treating medical practitioner and contact details; and/or
- Any other documentation, which may assist the Hostel in understanding and assessing the individual's care needs.

Acceptance of Resident

Acceptance is based not *only* on the receival of completed documentation and Resident satisfaction with the choice of Hostel.The availability and type of accommodation at the Hostel is affected by the history and category of the applicant; the dependency of the Resident; the amount and type of staff assistance, care and supervision required; the gender of the Resident;the Resident's choice of accommodation and any other special requirements.

Trial period

There is a mandatory requirement that all new Residents complete a *four week trial period.* The referring team/agency is responsible for the Resident during this period until formal acceptance by all parties and that these arrangements need to be given in writing to the Hostel. The Resident should bring in *two weeks medications*, *preferably four* and *two weeks board fees* for the trial period. In addition, the referral agency should inform the Resident of these arrangements and agree to an immediate transfer back if the trial proves unsatisfactory. It is important to note that some Residents may require a longer transition period, which will need agreement from all parties.

Referral Outcome

Notification of the referraloutcome will be conveyed in writing by the Hostel and may be one of four responses:

- the Referral Form is returned due to incomplete documentation with a request for further information;
- the applicant is refused admission;
- the applicant is acceptedfor a four week trial period; or
- theapplicant is accepted and placed on the waiting list.

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Acceptance of Applicant to admitting Hostel.
If the applicant is accepted the referring agency isthen responsible for organizing all appropriate referral documentation and will need to comply with the admitting Hostel's *Admission Policy* to ensure that all requirements of the policy will be met.

Additional documentationwill be required on admission:

- List of Resident's *Property and Valuables* (as attached);
- *Resident Authorisation* to release and/or obtain information from other agencies (as attached);

A copy of the *Admission Policy* is also attached for your information.

Availability of information to complete Referral Form
It is understood that some of the information requested by the Hostel may not be available, or is notapplicable. A notation 'Not known' or 'Not applicable (N/A)' should be documented in the relevant space. Otherwise, a response is required for each space.

Admitting Hostel Contact details

Name of Hostel: Burswood Care

Address: 16 Duncan Street, Victoria Park, WA 6100

Name of Licensee: Rosh Jalagge

Contact Person if not Licensee: Manager – Burswood Care

Phone number: (08) 9472 4579

Fax number: (08) 9361 3907

Email Address: burswoodcare@roshana.com.au

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APPLICANT INFORMATION AND PROFILE

FULL NAME: ***PREFERRED NAME:*** ***ALIAS:*** **MARITAL STATUS: M ☐ D ☐ S ☐**	**DOB:** **PLACE OF BIRTH:** **ETHNICITY:** **GENDER: M ☐ F ☐ OTHER ☐**
YEAR ARRIVED IN AUSTRALIA: **PREVIOUS ADDRESS:** **RECENT ACCOMMODATION HISTORY:**	**REASON FOR LEAVING LAST ACCOMMODATION:**
NEXT OF KIN OR GUARDIAN: **ADDRESS:**	**RELATIONSHIP:** **PHONE NUMBER:**
EMERGENCY CONTACT PERSON(S): **1.** **2.**	**PHONE NUMBERS:** **1.** **2.**
MEDICARE NUMBER: **PRIVATE HEALTH INSURANCE: Yes/No** **AMBULANCE COVER: Yes/No** **PUBLIC TRUSTEE: Yes/No** ***REFERENCE:*** **DVA: Yes/No**	**CENTRELINK/PENSION NUMBER:** **URN NUMBER:** **NAME AND FUND NUMBER:** **NAME AND PHONE NUMBER:** **PHONE NUMBER:** **DETAILS:**

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BURSWOOD CARE RESIDENT REFERRAL FORM

Licensee: Rosh Jalagge

REFERRAL SOURCE/AGENCY: CONTACT PERSON:	ADDRESS: PHONE AND FAX NUMBERS: EMAIL ADDRESS:
GP: PSYCHIATRIST: ATTENDING OR TREATING PHYSICIAN: MENTAL HEALTH CLINIC: CASE MANAGER: ADVOCATE:	ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER:

MENTAL HEALTH HISTORY AND DIAGNOSES:	GENERAL MEDICAL HEALTH HISTORY AND DIAGNOSES:
RESIDENT PERCEPTION OF MENTAL ILLNESS, THEIR TREATMENT AND MANAGEMENT:	RESIDENT PERCEPTION OF PHYSICAL ILLNESS, THEIR TREATMENT AND MANAGEMENT:
FORENSIC HISTORY:	CURRENT OR PENDING CHARGES:

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EDUCATION LEVEL: Left school before Year 10 **Yes/No** Basic level of education until Year 10 **Yes/No** Completed Year 12 **Yes/No**	Tertiary degree **Yes/No** Trade or professional qualification**Yes/No** Please name qualification:
DENTIST:	**ADDRESS AND PHONE NUMBER:**
ALLERGIES: ***(Can be either medication or food allergies)***	**CURRENT RISK OR GENERAL SAFETY ISSUES: Please include fire risk if applicable**

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CURRENT RESIDENT ASSESSMENT

Please complete this required assessment of the Resident, which will assist the Hostel in ensuring the transition will be as smooth as possible;there will be continuity of careand that safety and risk issues will beminimised.

Meals and Drinks

Resident competencies, degree of independence	*Nature of required staff assistance*
Choking Risk: Yes/No	

Personal Hygiene

Daily living activities	*Nature of required staff assistance*
Showering, bathing and washing Grooming, dressing, selecting clothing Skin care, finger and toenail care Brushing teeth/denture care	

Continence

Continence Status	*Continence Aids and regime*	*Nature of required staff assistance*
Urinary incontinence**Yes/No** Faecal incontinence**Yes/No** Catheter **Yes/No** Stoma **Yes /No**		

Mobility

Mobility Status and degree of independence	*Mobility aids required*	*Staff assistance required*
Falls Risk:: Yes/No	E.g. Walking stick, frame wheelchair	

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Living Environment and Care of Possessions

Resident competencies and degree of independence	*Staff assistance required*
Cleaning of room and making/changing bed: Care of Personal Possessions:	

Current Medications

(Please include all prescribed and PRN medications)

Name of medication	*Dosage and frequency*	*Route of administration*	*Staff assistance and Resident compliance*
			(E.g. Self-administration, 1 to 1 with staff standby)

ChallengingBehaviours

Behaviour	*Nature of behavior*	*Frequency of behaviour and last occurrence*	*Triggers*	*Management of behaviour*
Physical aggression **Yes/No**				
Verbal aggression **Yes/No**				
Intrusive behavior **Yes/No**				
Emotional dependence **Yes/No**				
Danger to self or others **Yes/No**				

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Behaviour	*Nature of Behaviour*	*Frequency of behaviour and last occurrence*	*Triggers*	*Management*
Inappropriate sexual behavior or vulnerability **Yes/No**				
Sleep disturbances **Yes/No**				
Alcohol, drugs or substance abuse **Yes/No**				
Any other bizarre, risky or unusual behaviour **Yes/No**				

Communication, Literacy and Numeracy

Competency	*Nature of deficit and degree of independence*	*Staff assistance and aids required*
Speech Impairment**Yes/No**		
Hearing Impairment**Yes/No**		
Visual Impairment**Yes/No**		
Non-English speaking or English as a second language **Yes/No**		
Literacy skills		
Numeracy skills		
Comprehension and cognitive skills		

Community Access

Competency	*Degree of independence and confidence*	*Staff assistance required*

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Uses public transport e.g. Bus, train, taxi**Yes/No**		
Considered safe when travelling alone on public transport and accessing the community.**Yes/No**		
Visits neighborhood shops, cafes and offices.**Yes/No**		
Drives own car**Yes/No**		
Prefers to walk everywhere**Yes/No**		

Health

Competency	*Degree of independence and confidence*	*Staff assistance required*
Makes own Doctor's and Dentist's appointments**Yes/No**		
Attends Doctor's and Dentist's consultations independently**Yes/No**		
Attends health promotion activities or programs**Yes/No**		

Current communicable or other disease

Disease	*Management and treatment*	*Staff assistance required*
Diabetes**Yes/No**		
Hepatitis**Yes/No**		
HIV**Yes/No**		
Other communicable disease, infectious conditionor chronic disease**Yes/No**		

Special Interventions required

Intervention	*Management and treatment*	*Staff assistance required*

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Blood sugar monitoring **Yes/No**		
Administration of Insulin **Yes/No**		
Stoma care **Yes/No**		
Weight monitoring **Yes/No**		
Nebuliser **Yes/No**		
Other		

munisation

Please advise whether Resident has current vaccination status *E.g. Polio, Tetanus/Diphtheria, Measles, Mumps, Whooping cough, Hepatitis A and B, Influenza, Meningococcus C, Pneumococcus, Rubella*

Disease	*Immunisation Status*

ental Health

Behaviour/Symptom	*Typeand description of symptom/behavior*	*Frequency of symptom/behaviour and last occurrence*	*Triggers*	*Management of symptom/behaviour*
Delusions **Yes/No**				
Hallucinations **Yes/No**				
Anxiety and Fearfulness **Yes/No**				

Financial Management

Competencies and financial information	*Assistance required e.g. Staff, Public Trustee, Centrelink, Family member,Friend*

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Manages all finances and budget independently **Yes/No**	
Manages small items but requires overall budgetary assistance **Yes/No**	
Requires full budgetary assistance **Yes/No**	
Rent assistance **Yes/No**	
Income per fortnight	

Psycho-Social

Please comment on the following:

Relationship with family and friends	
Links and personal networks	
Involvement in activities, internal or external to their previous accommodation, workshops, OT programs, day centres etc.	
Choice and/or potential to transition to independent living in the future	
Identified special interests or talents.	
Any known personal goals	

REFERRAL SOURCE/AGENCY

Name of Agency: ………………………..…………………………………………………

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Contact person's name and position: …………………………………………………………………………

Signature: ……………………………(**Psychiatrist/Case Manager**)Date:………..……………..

ANY FURTHER COMMENTS OR RELEVANT INFORMATION

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RECOMMENDATION

This recommendation must be made by the current Psychiatrist caring for the Resident.

I ………………………………………………………………………… (Psychiatrist name/Case Manager), confirm

that I have been caring for ……………………………………………………………. (Resident's name).

I believe that the facilities at Burswood Care will be suited to this potential Resident, as mentioned above and recommend that they should be granted a trial residency at this facility, located at 16 Duncan Street Victoria Park WA 6100.

Signed: ………………………………………… (Psychiatrist) Date: …………………

RESIDENT DISCLAIMER

I ……………………………………………….. (Resident's name), am aware that I have provided private, personal and confidential information about myself. I have provided this information of my own free will and aware that this information will be provided to Burswood Care. I acknowledge that the staff at Burswood Care may contact mental health professionals named on this form, to discuss personal information about myself. I give permission for the staff at Burswood Care to provide information outlined on this form to relevant health professional, GPs, Centrelink and Public Trust authorities, when deemed necessary by the staff at Burswood Care.

Signed: ………………………………………… (Resident) Date: …………………

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Thank you for completing this form. We will advise you as soon as possible regarding this application for admission to our Hostel.

Management
Burswood Care