
HONEYBROOK CARE RESIDENT REFERRAL FORM

HONEYBROOK CARE



DATE OF REFERRAL:

ADVICE TO REFERRING AGENCIES

Referral Procedure

Pre-admission

Prior to admission, we encourage the Referring Agency to bring potential Residents to Honeybrook Care so they can view the Hostel facility prior to submitting a referral form. This will ensure they are confident in their decision and happy with their choice to reside at Honeybrook Care.

Eligibility Criteria

- Resident aged 18+
- A diagnosed mental health condition
- History of severe mental health illness
- Impaired living and social skills meaning the person requires a supported living environment
- In receipt of a Disability Support Pension.

Referral Process

The process for assessment of referrals and potential admission into Honeybrook Care is listed in full below:

Process	
1	Individual visits Honeybrook Care to view facility and meet staff (preferred). Family and support people are encouraged to attend.
2	Completed Referral Form sent to Honeybrook Care Fax: 08 9250 5131 or email to honeybrook@roshana.com.au
3	Referral documentation sent to Swan Clinic or opinion on suitability.
4	Internal Assessment team reviews referral.
5	If Referral declined , the Referring Agency advised immediately
6	If Referral accepted , date of admission confirmed to all parties
9	If transition to hostel environment required, dates/times arranged.
10	All parties agree to work towards successful transition at all times.
11	Where a trial unsuccessful for undisclosed reasons or significant deterioration of mental health, Honeybrook Care will look to options ****

If any clarification or further information is required, please do not hesitate to contact Honeybrook Care staff.

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Referral Form

The Hostel Referral Form as follows, **must be completed in full** prior to the applicant being admitted for the initial four-week trial period. It is understood that some of the information requested by the Hostel may not be available at the time of completion, or is not applicable. In this instance, a notation 'Not known' or 'Not applicable (N/A)' should be written in the relevant space.

Assessment of this referral will not occur until all relevant information is obtained and as such, you will be contacted and requested to provide this information if anything is missing or any further information is required. This will ensure that there is adequate planning for the delivery of care and support required for the new resident and safety is maintained for other residents and staff

Trial period

There is a mandatory requirement that all new Residents complete a **four-week trial period**.

During this period, the Referring Agency is still responsible for the resident and in the event any unforeseen incident occurs which results in the resident not being suitable to reside at Honeybrook Care, we will contact you immediately to arrange an exit from the hostel. It is the responsibility of the Referring Agency to accept the resident back or arrange immediate alternative accommodation in the event the trial is not successful.

For those new residents coming from long-term hospital stays, we encourage the Referring Agency to plan and commence a Transition Plan into the hostel prior to admission. We believe this can alleviate high levels of anxiety at the change of accommodation and enables the new resident to begin to build new relationships with others and be familiar with their new surroundings in the hostel. In addition, we welcome input and visits from Family members and/or carers.

Admission

On the day of admission, an **Admission Pack** of documents will be provided to the new Resident, who will need to read and sign accordingly. These documents include:

- List of Resident's property and valuables;
- Authorization to release and/or obtain information from other agencies;
- Admission Policy
- Honeybrook Care rules, etc.

At time of admission, the Referral Agency and Resident must bring in the following:

- Four weeks medications (or 2 weeks + scripts);
- PRN medication (if required);
- Confirmation of payment for (2) weeks board and lodging fees + spending money for the trial period;
- Confirmation of the weekly/daily budget for the residents' spending money.

In addition, the Referral Agency must provide the following information if available:

If resident is leaving hospital:

- Care Transfer Summary;
- Pharmacy Notification Form (see page 8); and
- Discharge Summary must follow after the initial 4-week trial period.

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If resident is coming from a community setting:

- Current mental health assessment and care plan; and
- Details of current medication.

Any other documentation which may assist the Hostel in understanding and assessing the individual. This can include:

- Risk information including information on PSOLIS alerts and/or detailed risk assessments;
- Any care plans, such as the current mental health care plan, Crisis Awareness Plan and/or Recovery plans;
- The Statewide Standardised Mental Health Assessment (SMHMR902);
- A detailed social and personal history.

It is important to note that some Residents may require a longer transition period, which will need agreement from all parties. This can be arranged prior to admission to the hostel.

For more information on referrals at Honeybrook Care, please contact:

Facility Manager

08 9250 5225

honeybrook@roshana.com.au

General Information on Honeybrook Care Facility:

Address: 42 John Street, Midland WA 6056

Phone: 08 9250 5225

Fax: 08 9250 5131

Licensee: honeybrook@roshana.com.au

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APPLICANT INFORMATION AND PROFILE

<p>FULL NAME:</p> <p><i>PREFERRED NAME:</i></p> <p>ALIAS:</p> <p>MARITAL STATUS: M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/></p>	<p>DOB:</p> <p>PLACE OF BIRTH:</p> <p>ETHNICITY:</p> <p>GENDER: M <input type="checkbox"/> F <input type="checkbox"/> OTHER <input type="checkbox"/></p>
<p>YEAR ARRIVED IN AUSTRALIA:</p> <p>PREVIOUS ADDRESS:</p> <p>RECENT ACCOMMODATION HISTORY:</p>	<p>REASON FOR LEAVING LAST ACCOMMODATION:</p>
<p>NEXT OF KIN OR GUARDIAN:</p> <p>ADDRESS:</p>	<p>RELATIONSHIP:</p> <p>PHONE NUMBER:</p>
<p>EMERGENCY CONTACT PERSON(S):</p> <p>1.</p> <p>2.</p>	<p>PHONE NUMBERS:</p> <p>1.</p> <p>2.</p>
<p>MEDICARE NBR:</p> <p>EXPIRY DATE:</p> <p>PRIVATE HEALTH INSURANCE: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AMBULANCE COVER: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>CENTRELINK/PENSION NBR:</p> <p>URN NBR:</p> <p>NAME & FUND NBR:</p> <p>NAME & FUND NBR:</p>

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<p>PUBLIC TRUSTEE: <input type="checkbox"/> Yes <input type="checkbox"/> No Trustee Reference Number: TM Number:</p> <p>DVA: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Trust Managers Name: Contact PHONE NBR:</p> <p>NAME & PHONE NBR:</p>
<p>REFERRAL SOURCE/AGENCY:</p> <p>CONTACT PERSON:</p>	<p>ADDRESS:</p> <p>PHONE / FAX CONTACT:</p> <p>EMAIL ADDRESS:</p>
<p>GP:</p> <p>PSYCHIATRIST:</p> <p>ATTENDING OR TREATING PHYSICIAN:</p> <p>MENTAL HEALTH CLINIC:</p> <p>CASE MANAGER:</p> <p>ADVOCATE:</p>	<p>ADDRESS: PHONE:</p> <p>ADDRESS: PHONE:</p> <p>ADDRESS: PHONE:</p> <p>ADDRESS: PHONE:</p> <p>ADDRESS: PHONE:</p> <p>ADDRESS: PHONE:</p>

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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:
DENTIST:	ADDRESS & PHONE NBR:
ALLERGIES: (Can be either <u>medication</u> or <u>food allergies</u>)	CURRENT RISK OR GENERAL SAFETY ISSUES:
EDUCATION LEVEL: Left school before Yr 10 <input type="checkbox"/> Yes <input type="checkbox"/> No Basic level of education until Yr 10 <input type="checkbox"/> Yes <input type="checkbox"/> No Completed Year 12 <input type="checkbox"/> Yes <input type="checkbox"/> No	Tertiary degree <input type="checkbox"/> Yes <input type="checkbox"/> No Trade or professional qualification <input type="checkbox"/> Yes <input type="checkbox"/> No Please name qualification:

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BRIEF RISK ASSESSMENT

SOURCE OF INFORMATION:		<input type="checkbox"/> The Consumer			<input type="checkbox"/> Immediate carer (parent, spouse, child)		
<input type="checkbox"/> Other informants (family, friends)		<input type="checkbox"/> Previous clinical records			<input type="checkbox"/> Assessing clinician's knowledge of consumer's past behavior/current clinical presentation		
<input type="checkbox"/> Police / ambulance / other agencies		<input type="checkbox"/> Other (please specify)					
SUICIDALITY (Static historical) factors	Yes (1)	No (0)	Not known	Dynamic (current) risk factor	Yes (2)	No (0)	Not known
Previous attempt(s) on own life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous serious attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has plan / intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expresses high level of distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major psychiatric diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness/perceived loss of coping or control over life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major physical disability/illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent significant life event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Separated / Widowed / Divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of job / retired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs / alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROTECTIVE FACTORS (describe):							
LEVEL OF SUICIDE RISK (total score): <input type="checkbox"/> LOW (<7) <input type="checkbox"/> MODERATE (7-14) <input type="checkbox"/> HIGH (> 14)							
AGGRESSION / VIOLENCE Static (historical) factors	Yes (1)	No (0)	Not known	Dynamic (current) risk factor	Yes (2)	No (0)	Not known
Recent incidents of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expressing intent to harm others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous use of weapons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to available means	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation about others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under 35 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violent command hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, frustration or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous dangerous acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preoccupation with violent ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate sexual behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Role instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced ability to control self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of drug/alcohol misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current misuse of drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROTECTIVE FACTORS (describe):							
LEVEL OF VIOLENCE RISK (total score): <input type="checkbox"/> LOW (<7) <input type="checkbox"/> MODERATE (7-14) <input type="checkbox"/> HIGH (> 14)							
OTHER RISKS IDENTIFIED (AND RISK FACTORS)							
RISK MANAGEMENT ISSUES (Please ensure alerts are noted here)							

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ADDITIONAL FORMS REQUIRED FOR REFERRAL:

Attach Pharmacy Notification Form

Attached? Yes No

Attach Care Transfer Summary

Attached? Yes No

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CURRENT RESIDENT ASSESSMENT

Please complete the following assessment of the Resident, which will assist the Hostel in organizing the transition to be as smooth as possible ensuring continuity of care and minimizing any potential safety and risk issues.

Meals and Drinks

<i>Resident competencies, degree of independence</i>	<i>Nature of required staff assistance</i>
<p>CHOKING RISK?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Personal Hygiene

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

Continence

<i>Continence Status</i>	<i>Continence Aids and regime</i>	<i>Nature of required staff assistance</i>
Urinary incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No		
Faecal incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No		
Catheter <input type="checkbox"/> Yes <input type="checkbox"/> No		
Stoma <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Mobility

<i>Mobility Status and degree of independence</i>	<i>Mobility aids required</i>	<i>Staff assistance required</i>
	E.g. Walking stick, frame wheelchair	
FALLS RISK?: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Living Environment and Care of Possessions

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

Current Medications

(Please include all prescribed and PRN medications)

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

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Challenging Behaviours

BEHAVIOUR	
Physical aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Verbal aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Intrusive behavior <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Emotional dependence <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Danger to self or others <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
BEHAVIOUR	
Inappropriate sexual Behavior /Vulnerability <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Sleep disturbances <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Alcohol, drugs or substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Any other bizarre, risky or unusual behaviour <input type="checkbox"/> Yes <input type="checkbox"/> No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:

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Communication, Literacy and Numeracy

<i>Competency</i>	<i>Nature of deficit and degree of independence</i>	<i>Staff assistance and aids required</i>
Speech Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		
Visual Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		
Non-English speaking or English as a second language <input type="checkbox"/> Yes <input type="checkbox"/> No		
Literacy skills		
Numeracy skills		
Comprehension and cognitive skills		

Community Access

<i>Competency</i>	<i>Degree of independence and confidence</i>	<i>Staff assistance required</i>
Uses public transport e.g. bus, train, taxi <input type="checkbox"/> Yes <input type="checkbox"/> No		
Considered safe when travelling alone on public transport and accessing the community. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Visits neighbourhood shops, cafes and offices. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Drives own car <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prefers to walk everywhere <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Health

<i>Competency</i>	<i>Degree of independence and confidence</i>	<i>Staff assistance required</i>
Makes own appointments with doctor, dentist, podiatrist <input type="checkbox"/> Yes <input type="checkbox"/> No		
Attends doctor, dentist, podiatrist independently <input type="checkbox"/> Yes <input type="checkbox"/> No		
Attends health promotion activities or programs <input type="checkbox"/> Yes <input type="checkbox"/> No		

Current communicable or other disease

<i>Disease</i>	<i>Management and treatment</i>	<i>Staff assistance required</i>
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No		
HIV <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other communicable disease, infectious condition or chronic disease <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Special Interventions required

<i>Intervention</i>	<i>Management and treatment</i>	<i>Staff assistance required</i>
Blood sugar monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No		
Administration of Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No		
Stoma care <input type="checkbox"/> Yes <input type="checkbox"/> No		
Weight monitoring <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nebuliser <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:		

Immunisation

Please advise whether Resident has current vaccination status E.g. COVID-19, Polio, Tetanus/Diphtheria, Measles, Mumps, Whooping cough, Hepatitis A and B, Influenza, Meningococcus C, Pneumococcus, Rubella

<i>Disease</i>	<i>Immunisation Status</i>		
Covid-19	<i>First dose (date):</i>	<i>Second dose (date):</i>	<i>Booster (date):</i>

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Mental Health

BEHAVIOUR & SYMPTOMS	
Delusions <input type="checkbox"/> Yes <input type="checkbox"/> No	Type & description: <hr/> Frequency & last occurrence: <hr/> Triggers & signs of relapse: <hr/> Management: <hr/>
Hallucinations <input type="checkbox"/> Yes <input type="checkbox"/> No	Type & description: <hr/> Frequency & last occurrence: <hr/> Triggers & signs of relapse: <hr/> Management: <hr/>
Anxiety and Fearfulness <input type="checkbox"/> Yes <input type="checkbox"/> No	Type & description: <hr/> Frequency & last occurrence: <hr/> Triggers & signs of relapse: <hr/> Management: <hr/>

Mental Health

Is there a current Crisis Management Plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide details or attach a copy to this referral.

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Psycho-Social

Please comment on the following:

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

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Financial Management

<i>Competencies and financial information</i>	<i>Assistance required</i> <i>e.g. Staff, Public Trustee, Centrelink, Family member, Friend</i>
Manages all finances and budget independently <input type="checkbox"/> Yes <input type="checkbox"/> No	
Manages small items but requires overall budgetary assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Requires full budgetary assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rent assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Benefit: (e.g, DSP) Enter benefit type:	Income per fortnight: Enter income amount

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REFERRAL SOURCE/AGENCY

Name of Agency:

Contact person's name and position:

Signature: (Psychiatrist/Case Manager) Date:

ANY FURTHER COMMENTS OR RELEVANT INFORMATION

.....
.....
.....

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 Honeybrook 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

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 Honeybrook Care. I acknowledge that the staff at Honeybrook Care may contact mental health professionals named on this form, to discuss personal information about myself. I give permission for the staff at Honeybrook 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 Honeybrook Care.

Signed: (Resident) Date:

Thank you for completing this form. We will advise you as soon as possible regarding this application for admission to our Hostel. Do not hesitate to contact Honeybrook Care if you have any queries.

Management
Honeybrook Care