

SRS Referral Form

Name of SRS Berwick House Supported Residential Service

PART A: for completion by client or client's representative (if applicable)

Consent to release information

I _____ consent for the information collected on the attached SRS Referrals Form to be released to the SRS provider who will be providing accommodation and care to me.

Signed -----Date -----

Representative name -----

Representative relationship -----Telephone -----

PART B: FOR COMPLETION BY REFERRER

Reason for referral to SRS

I _____ am familiar with the _____ SRS and the service 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-----

<If the client is residing in another SRS>

Name of facility-----Telephone number of SRS-----

Date of birth-----Gender: Male Female

Language spoken-----Religion-----

Does the client have Private Health Insurance Yes /No

Insurer-----Reference No.-----

Disability

Is the client registered with the Disability Services (DHS)? Yes/No

What is the primary disability? -----

Name of the Case Manager -----Telephone no -----

Name of Psychiatrist -----Telephone no -----

Behaviour

List of behaviour that may require special consideration (please circle the one appropriate)

Self-harm Smoking Self- motivation Capacity for cooperation Physical aggression

Wandering Capacity to share Capacity to socialize Verbal aggression Drug/Alcohol

I
Impulse control Other

Details -----

Personal Care

	No Assistance	Prompting/Supervision	Active Assistance
Eating/drinking/diet	Yes/No	Yes/No	Yes/No
Mobility	Yes/No	Yes/No	Yes/No
Showering/bathing	Yes/No	Yes/No	Yes/No
Shaving/bathing	Yes/No	Yes/No	Yes/No
Dressing	Yes/No	Yes/No	Yes/No
Dental hygiene	Yes/No	Yes/No	Yes/No
Toileting	Yes/No	Yes/No	Yes/No
Foot care/nail care	Yes/No	Yes/No	Yes/No

Medical Practitioner

Name -----Telephone -----

Address -----Suburb-----Postcode-----

Does the client have a Guardian Yes/No/ an Administrator Yes/No

Name-----Telephone-----

Address-----Suburb-----Postcode-----

Reference no.-----

Pension Details (circle the applicable one)

Type of income: Centrelink/ Veterans' Affairs/ Overseas pension

Client Reference no: -----

Medicare Number: ----- Expiry date -----

Tax Concession Card Number: ----- Expiry date -----