Acland Grange *Supported Residential Service* ABN: 51 672 867 259

166-168 Barkly Street, St Kilda 3182
Phone: (03) 9525 3922
Proprietor: Li Ping 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.

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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:** _____

Representative relationship: _____ **Mobile:** _____

[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** ☐ **Other**

Language Spoken: _____ **Religion:** _____

Does your Client Identify as Aboriginal/Torres Strait Islander? ☐ **Yes** ☐ **No**

Does the Client Have Private Health Insurance: ☐ **Yes** ☐ **No**

Insurer: _____ **Reference No.** _____

Has the client been informed of the expectations, nature, purpose, and limitations of an SRS facility, and do they demonstrate an understanding of these? ☐ **Yes** ☐ **No**

[If Client is residing in another SRS or has previously stayed in another SRS]

Name of Facility: _____ **Telephone No. of SRS:** _____

Address: _____ **Length of stay Months/Years or Date period:** _____

Name of Facility: _____ **Telephone No. of SRS:** _____

Address: _____ **. Length of stay Months/Years or Date period:** _____

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Next of Kin Details.

Name: **Relationship:**

Adress: **Suburb**

Postcode:

Medical Practitioner.

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:

Drug Name:	Drug Name:	Drug Allergy Name	Allergy Side Effect

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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:**

Physical Health Status.

Any physical health issues (e.g., injuries, disabilities, diseases, ailments, or other considerations)?
☐ Yes ☐ No
If yes, then please briefly list any physical health issues and how to best manage them.

……

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Referral Form.

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:**	☐	**Emotional Regulation**	☐
Heightened Anxiety	☐	**Paranoia**	☐	**Other**	☐		

Other Details:

If any of the boxes is ticked for any of the above, please provide a brief expansion on the identified behaviour. This should include an explanation of the typical triggers that lead to the behaviour, the frequency with which it occurs, the severity or level of impact it presents, and the strategies that are most effective in managing it. Alternatively, if the client already has a Behaviour Support Plan (BSP) in place, a copy of that plan may be attached to the referral in place of the above details.

Criminal History Declaration.

Have you ever been convicted of a criminal offence? ☐ Yes ☐ No

If yes is ticked above, please circle the relevant charge(s) from the following list:
Theft, Property Damage, Arson, Drug Trafficking, Physical Assault, Sexual Assault, Manslaughter/Murder.
If the charges are not listed above, please specify here:

Please provide details of the offence including the nature, date, sentence or outcome, and whether the matter is past or ongoing.

If the offence is ongoing, please expand further by outlining the status of proceedings, probation, parole, or appeal, and provide any relevant information about expected timelines or conditions. This ensures that the facility have a clear understanding of the situation and can manage compliance appropriately.

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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 the 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 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?

Food Allergens and Preferences.

Does the client have a food allergy? ☐ Yes ☐ No
If yes, what is the food allergen and side effects:

Does the client have a food preference? ☐ Yes ☐ No
If yes, what are the client's food preferences:

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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:**