Westpeak Residential Services

Location of facility: ………………………………………

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 Westpeak 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.** ………………………

If not residing at another SRS, what are their current living circumstances?

....

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

Insurer .... **Reference No.** ....

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**
OR AN ADMINISTRATOR? ☐**Yes** ☐**No**
Name.. **Telephone** ....
Address.. **Suburb** ....
Postcode............................. **Client Reference no.** ....

PENSION DETAILS
Type of income ☐**DSP** ☐**NEWSTART** ☐**VETERAN'S AFFAIRS** ☐**OTHER**
Client Reference no. ....
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**
Does the client use a dosette or webstar pack? ☐**Yes** ☐**No**

Is the client compliant with their medication? ☐**Yes** ☐**No**

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

PHYSICAL STATUS

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

Please give details of medical conditions for our records…………………………………………………
………..
………..

Is client's current health status expected to remain stable? ☐**Yes** ☐**No**

Has the client had any relevant surgical procedures? ☐**Yes** ☐**No**

If yes, please give details………………………………………………………………………………….

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**

If yes to any questions above, please provide details ..……………………………………………………….
………
………

DISABILTY

Is the client registered with Disability Services (DHS)? ☐**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**

If yes, please specify conditions ………………………………………………………………………………
…….

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

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 ☐ Absconding

WESTPEAK
RESIDENTIAL SERVICES

Other ☐
Details …………………………………………………………………………………………………..
……
……
………………………………………………………………………………………………………...

PERSONAL CARE

	No Assistance	**Prompting/ Supervision**	**Active Assistance**	
Eating/drinking/diet	☐	☐	☐	Special diet? ☐**Yes** ☐**No**
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 independently? ☐**Yes** ☐**No**
Is client able to make and keep appointments? ☐**Yes** ☐**No**
Is client able to maintain a clean, tidy room environment? ☐**Yes** ☐**No**
Has client held employment and or participated in education in the past? ☐**Yes** ☐**No**
If yes, what education/employment position was held? ....
……

RECREATION/SOCIALISATION

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** …..…………………………………

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 A REFERRAL BEEN MADE FOR 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/DETAILS

……………………………………………………………………………………………………
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Name…………………………………………………………………………

Position……………………………………………………………

Organisation…………………………………………………………

Signature…………………………………………………………

Date…………………………………………