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| **Name of SRS:** | **Murphy House – 5-7 Murphy Street, Kennington** |

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| **PART A: for completion by Participant or Participant’s Representative** | | | | | | | | | |
| Consent to Release Information | | | | | | | | | |
|  | | | | | | | | | |
| I, |  | | | | | | | |  |
|  | (Name of person giving this consent) | | | | | | | | |
| Consent for the information collected on this SRS Referral Form to be released to the SRS provider who will be providing accommodation and care to: | | | | | | | | | |
| Name: |  | | | | | | | |  |
|  | (Name of person being referred if different from above) | | | | | | | | |
| Signed: |  | | | | | | Date: |  |  |
|  | (Signature of person giving this consent) | | | | | | | | |
| Representative Name: | | |  | | | |  | | |
|  | |  | | | | |  | | |
| Representative Relationship: | | |  | | Phone No: |  | | |  |
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| **PART B: for completion by Referrer** | | | | | | | | | | | | |
| Reason for Referral to SRS | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| I, |  | | | | | | | | | | |  |
|  | (Name of person giving this referral) | | | | | | | | | | | |
| am familiar with the above-named SRS and the services it provides to participants. I consider that referral of this participant to the SRS is appropriate because: | | | | | | | | | | | | |
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| Signed: |  | | | | | | | | | Date: |  |  |
|  | (Signature of person giving this referral) | | | | | | | | | | | |
| Representative Name: | | |  | | | | | | |  | | |
|  | | | |  | | | | | |  | | |
| Position: | |  | | | | Agency: |  | Phone No: |  | | |  |
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| **Participant Details** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Surname: |  | First Name: |  | | | | | | | | |  |
|  |  |  |  | | | | | | | | |  |
| Date of Birth: |  | Gender |  | Male | | |  | Female | |  | Non-binary |  |
|  |  |  |  | | | | | | | | |  |
| Religion: |  | Language: |  | | | | | | | | |  |
|  |  |  |  | | | | | | | | |  |
| Current |  | | | | | | | | | | |  |
| Address: |  | | | | | | | | | | |  |
|  |  | | | | | | | | | | |  |
|  | If Participant is residing in another SRS | | | |  | | | | | | |  |
| Name of SRS: |  | | | |  | Phone No: | | |  | | |  |
|  | If the Participant has Private Health Insurance | | | |  |  | | |  | | |  |
| Insurer: |  | | | |  | Ref No: | | |  | | |  |
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| **Next of Kin Details** | | | | | | | |
|  | | | | | | | |
| Surname: |  | First Name: |  | | | |  |
|  |  |  |  | | | |  |
| Relationship: |  | Phone: |  | | | |  |
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| Address: |  | | | | | |  |
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| **Medical Practitioner Details** | | | | | | | |
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| Surname: |  | First Name: |  | | | |  |
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| Address: |  | | | | | |  |
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| **Guardian Details (If Applicable)** | | | | | | | |
|  | | | | | | | |
| Surname: |  | First Name: |  | | | |  |
|  |  |  |  | | | |  |
| Ref No: |  |  | | | | |  |
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| **Administrator Details (If Applicable)** | | | | | | | |
|  | | | | | | | |
| Surname: |  | First Name: |  | | | |  |
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| Phone: |  |  | | | | |  |
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| Address: |  | | | | | |  |
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| **Pension Details** | | | | | | | |
|  | | | | | | | |
| Type of Income: |  | Centerlink |  | Veteran’s Affairs | | |  |
|  |  |  |  |  | | |  |
|  |  | Overseas Pension |  | Other (Give details) | |  |  |
|  |  | |  | |  | |  |
| Ref No: |  | | Medicare No: | |  | |  |
|  |  | |  | |  | |  |
| Taxi Conc No: |  | | Expiry Date: | |  | |  |
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| **Medication Details (this information is to be provided by the Participant’s Medical Practitioner)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | Drug Name: | | Dose: | | Frequency: | | Duration: | | | | Last Taken: |  |
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|  | Does the Participant have the medication with them? | | | | | |  | Yes |  | No | |  |
|  |  | | |  | | |  |  |  |  | |  |
|  | Is the Participant able to administer their own medication? | | | | | |  | Yes |  | No | |  |
|  |  | | | | | |  |  |  |  | |  |
|  | Please specify any anticipated side effects of medication. | | | | | |  |  |  |  | |  |
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| **Physical Status** | | | | | | | |
|  | Please list any pre-existing medical conditions or allergies | | | | | | |
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| **Cognitive Status** | | | | | | | |
|  | Please list any cognitive issues to which SRS staff need to be alerted E.g. orientation to time and place, independence in decision making, memory impairment etc. | | | | | | |
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| **Mental Health Status** | | | | | | | | |
|  | Please specify any mental health issues to which staff need to be alerted. | | | | | | | |
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|  | (If the Participant is subject to a Community Treatment Order) | | | | | | | |
|  |  | | | | | | | |
|  | Case Manager: |  | | Phone: | |  | |  |
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| **Disability** | | | | | | | | | | | | | | | | | | | | | | | |
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| Disability: |  | Psychosocial | | | |  | Intellectual | |  | Mental Health | | |  | Autism | |  | | Physical | | | | |  |
|  |  |  | | | |  |  | |  |  | | |  |  | |  | |  | | | | |  |
|  |  | Other | | | |  | | | | | | | | | | | | | | | | |  |
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| NDIS No: |  | | | | Support Coordinator | | | | |  | | | | | | Phone: | | | |  | | |  |
|  |  | |  | | | | | | | |  | | | |  | | | | | | | |  |
| NDIS Plan | Start Date | | |  | | | | End Date |  | | Plan Included? | | | |  | | Yes | | | |  | No | | |
|  |  | |  | | | | | | | |  | | | |  | | | | | | | |  |
| Billing Details | |  | NDIA | | | |  | Third Party | | |  | Self-Managed | | | | | | | | | | |  |
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| **Behaviour** | | | | | | | | | | | | | | |
| **Select any behaviour that may require special consideration.** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  |  | Self-harm | |  | Impulse Control | | |  | Capacity to cooperate | | |  | Capacity to share | |
|  |  |  | |  |  | | |  |  | | |  |  | |
|  |  | Wandering | |  | Drug/Alcohol | | |  | Physical aggression | | |  | Capacity to socialise | |
|  |  |  | |  |  | | |  |  | | |  |  | |
|  |  | Self-motivation | |  | Smoking | | |  | Verbal aggression | | |  | Other | |
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| **Details** | | | | | | | | | | | | | | |
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|  | **List any known ‘Triggers’ for behaviours of concern.** | | | | | | | | | | | | |  |
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|  | Behavioural Support Plan in place? | | | | |  | Yes |  | No |  | | | |  |
|  |  | |  | | | | | | |  | | | |  |
|  | Practitioner Name: | |  | | | | | | | Phone: |  | | |  |
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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 | ☐ | ☐ | ☐ |
| Housekeeping | ☐ | ☐ | ☐ |

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| **Aids and Appliances** | | | | | | | | | | | | | | | | |
|  | | | | | | |  |  | | |  |  | | | | |
| Does the Participant use any aids or appliances? | | | | | | |  | Yes | | |  | No | | | | |
|  | | | | | | |  | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | |
| Mobility: | | |  | Stick |  | Frame | | |  | Wheelchair | | |  | Other |  |  |
|  | | | | | | | | | | | | | | | | |
| Communication: | | |  | Glasses |  | Hearing Aid | | |  | Interpreter | | |  | Other |  |  |
|  | | | | | | | | | | | | | | | |  |
| Other: | | |  | Dentures |  | Continence Aids | | | | | | | | | |  |
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|  | Comments | | | | | | | | | | | | | | |  |
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| **Community Living Skills** | | | | | | |
|  | |  |  |  |  | |
| Is the Participant able to access public transport? | |  | Yes |  | No | |
|  | | | | | | |
| Is the Participant able to make and keep appointments | |  | Yes |  | No | |
|  |  | | | | |  |

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| --- | --- | --- |
| **Recreation and Socialisation** | | |
|  | | |
|  | **List any community-based activities the Participant attends.** |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **List any hobbies or special interest the Participant may have.** |  |
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| **Health and Community Services** | | | | | | | | | | |
| If the Participant has a Case Manager | | | | | | | | | | |
|  | | | | | | | | | | |
| Surname: |  | First Name: | | |  | | | | |  |
|  |  |  | | |  | | | | |  |
| Organisation: |  | | | | | | | | |  |
|  |  |  | | |  | | | | |  |
| Address: |  | | | | | | | | |  |
|  |  | | | | | | | | |  |
| If the Participant currently accesses other services, please provide details: | | | | | | |  |  |  |  |
|  |  | | | | | |  |  |  |  |
| Organisation: |  | | | | | | | | |  |
|  |  |  | | |  | | | | |  |
| Contact: |  | |  | Phone: | |  | | | |  |
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| **Other Relevant Information** | | | | | | | | | | |
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|  | Name: |  | | Position: | |  | | | |  |
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|  | Organisation: |  | | Date: | |  | | | |  |
|  | | | | | | | | | | |
|  | Signature: |  | |  | | | | | | |
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