
BP LUXURY CARE RESIDENT REFERRAL FORM



DATE OF REFERRAL:

BP LUXURY CARE RESIDENT REFERRAL FORM

Licensee: ROSH JALAGGE

ADVICE TO REFERRING AGENCIES

REFERRAL PROCEDURE

Pre-admission

It is preferable that potential Residents view the Hostel, before referral forms are submitted, so that they are confident in their decision to reside at this particular Hostel. A final decision cannot be made unless this process is followed and the Resident is happy with their choice.

Referral Form

The Hostel Referral Form as follows, *must be completed in full* prior to the applicant being admitted for the initial trial period. New Residents will not be admitted and assessment of the information will not occur before all relevant information is obtained from the Referral Agency. This requirement is mandatory and ensures as much as possible, that the delivery of care is seamless, the care is adequately planned and delivered and Resident and Staff safety is optimised.

Additional required documentation for admission.

Apart from the completed Referral Form, other documentation is required if applicable:

- A copy of the Discharge Summary if leaving Hospital e.g. mental and physical diagnoses; any infectious diseases; reason for admission; treatment provided; current medications and discharge plan;
- A current mental health assessment and plan;
- A current risk assessment, outlining current and past risks;
- The name of the current treating medical practitioner and contact details; and/or
- Any other documentation, which may assist the Hostel in understanding and assessing the individual's care needs.

Acceptance of Resident

Acceptance is based not *only* on the receipt of completed documentation and Resident satisfaction with the choice of Hostel. The availability and type of accommodation at the Hostel is affected by the history and category of the applicant; the dependency of the Resident; the amount and type of staff assistance, care and supervision required; the gender of the Resident; the Resident's choice of accommodation and any other special requirements.

Trial period

There is a mandatory requirement that all new Residents complete a *four week trial period*. The referring team/agency is responsible for the Resident during this period until formal acceptance by all parties and that these arrangements need to be given in writing to the Hostel. The Resident should bring in *two weeks medications, preferably four and two weeks board fees* for the trial period. In addition, the referral agency should inform the Resident of these arrangements and agree to an immediate transfer back if the trial proves unsatisfactory. It is important to note that some Residents may require a longer transition period, which will need agreement from all parties.

Referral Outcome

Notification of the referral outcome will be conveyed in writing by the Hostel and may be one of four responses:

- the Referral Form is returned due to incomplete documentation with a request for further information;
- the applicant is refused admission;
- the applicant is accepted for a four week trial period; or
- the applicant is accepted and placed on the waiting list.

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Acceptance of Applicant to admitting Hostel.

If the applicant is accepted the referring agency is then responsible for organizing all appropriate referral documentation and will need to comply with the admitting Hostel's *Admission Policy* to ensure that all requirements of the policy will be met.

Additional documentation will be required on admission:

- List of Resident's *Property and Valuables* (as attached);
- *Resident Authorisation* to release and/or obtain information from other agencies (as attached);

A copy of the *Admission Policy* is also attached for your information.

Availability of information to complete Referral Form

It is understood that some of the information requested by the Hostel may not be available or is not applicable. A notation 'Not known' or 'Not applicable (N/A)' should be documented in the relevant space. Otherwise, a response is required for each space.

Admitting Hostel Contact details

Name of Hostel: BP Luxury Care

Address: 20-22 The Crescent, Maddington, WA 6109

Name of Licensee: Rosh Jalagge

Contact Person if not Licensee: Manager – BP Luxury Care

Phone number: (08) 9459 8882

Fax number: (08) 9459 8884

Email Address: bpluxuryc@gmail.com

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REFERRAL SOURCE/AGENCY: CONTACT PERSON:	ADDRESS: PHONE AND FAX NUMBERS: EMAIL ADDRESS:
GP: PSYCHIATRIST: ATTENDING OR TREATING PHYSICIAN: MENTAL HEALTH CLINIC: CASE MANAGER: ADVOCATE:	ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER: ADDRESS AND PHONE NUMBER:

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:

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EDUCATION LEVEL: Left school before Year 10 Yes/No Basic level of education until Year 10 Yes/No Completed Year 12 Yes/No	Tertiary degree Yes/No Trade or professional qualification Yes/No Please name qualification:
DENTIST:	ADDRESS AND PHONE NUMBER:
ALLERGIES: <i>(Can be either <u>medication</u> or <u>food allergies</u>)</i>	CURRENT RISK OR GENERAL SAFETY ISSUES:(Please include fire risk if relevant)

CONFIDENTIAL

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CURRENT RESIDENT ASSESSMENT

Please complete this required assessment of the Resident, which will assist the Hostel in ensuring the transition will be as smooth as possible there will be continuity of care and that safety and risk issues will be minimised.

Meals and Drinks

<i>Resident competencies, degree of independence</i>	<i>Nature of required staff assistance</i>
<p>Choking Risk: Yes/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 Yes/No		
Faecal incontinence Yes/No		
Catheter Yes/No		
Stoma Yes /No		

Mobility

<i>Mobility Status and degree of independence</i>	<i>Mobility aids required</i>	<i>Staff assistance required</i>
<p>Falls Risk:: Yes/No</p>	E.g. Walking stick, frame wheelchair	

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

Challenging Behaviours

<i>Behaviour</i>	<i>Nature of behavior</i>	<i>Frequency of behaviour and <u>last occurrence</u></i>	<i>Triggers</i>	<i>Management of behaviour</i>
Physical aggression Yes/No				
Verbal aggression Yes/No				
Intrusive behavior Yes/No				
Emotional dependence Yes/No				
Danger to self or others Yes/No				

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<i>Behaviour</i>	<i>Nature of Behaviour</i>	<i>Frequency of behaviour and last occurrence</i>	<i>Triggers</i>	<i>Management</i>
Inappropriate sexual behavior or vulnerability Yes/No				
Sleep disturbances Yes/No				
Alcohol, drugs or substance abuse Yes/No				
Any other bizarre, risky or unusual behaviour Yes/No				

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 Yes/No		
Hearing Impairment Yes/No		
Visual Impairment Yes/No		
Non-English speaking or English as a second language Yes/No		
Literacy skills		
Numeracy skills		
Comprehension and cognitive skills		

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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 Yes/No		
Considered safe when travelling alone on public transport and accessing the community. Yes/No		
Visits neighborhood shops, cafes and offices. Yes/No		
Drives own car Yes/No		
Prefers to walk everywhere Yes/No		

Health

<i>Competency</i>	<i>Degree of independence and confidence</i>	<i>Staff assistance required</i>
Makes own Doctor's and Dentist's appointments Yes/No		
Attends Doctor's and Dentist's consultations independently Yes/No		
Attends health promotion activities or programs Yes/No		

Current communicable or other disease

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

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Special Interventions required

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

Immunisation

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

<i>Disease</i>	<i>Immunisation Status</i>

Mental Health

<i>Behaviour/ Symptom</i>	<i>Type and description of symptom/ behavior</i>	<i>Frequency of symptom/ behaviour and <u>last occurrence</u></i>	<i>Triggers</i>	<i>Management of symptom/ behaviour</i>
Delusions Yes/No				
Hallucinations Yes/No				
Anxiety and Fearfulness Yes/No				

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Financial Management

<i>Competencies and financial information</i>	<i>Assistance required e.g. Staff, Public Trustee, Centrelink, Family member, Friend</i>
Manages all finances and budget independently Yes/No	
Manages small items but requires overall budgetary assistance Yes/No	
Requires full budgetary assistance Yes/No	
Rent assistance Yes/No	
Income per fortnight	

Psycho-Social

Please comment on the following:

Relationship with family and friends	
Links and personal networks	
Involvement in activities, internal or external to their previous accommodation, workshops, OT programs, day centres etc.	
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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REFERRAL SOURCE/AGENCY

Name of Agency:

Contact person's name and position:

Signature: (Psychiatrist/Case Manager) Date:

ANY FURTHER COMMENTS OR RELEVANT INFORMATION

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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 BP Luxury 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 BP Luxury Care. I acknowledge that the staff at BP Luxury Care may contact mental health professionals
named on this form, to discuss personal information about myself. I give permission for the staff at BP Luxury 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 BP Luxury Care. By giving my consent, I also consent to my medical history, mental
health history and personal information being provided to BP Luxury by my treating Doctor, Mental Health Team, Case
Manager or other relevant professional.

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.

**Management
BP Luxury Care**