BURSWOOD CARE RESIDENT REFERRAL FORM

BURSWOOD CARE

ROSHANA CARE GROUP

DATE OF REFERRAL: …….

ADVICE TO REFERRING AGENCIES

Referral Procedure

Pre-admission

Prior to admission, we encourage the Referring Agency to bring potential Residents to Burswood Care so they can view the Hostel facility prior to submitting a referral form. This will ensure they are confident in their decision and happy with their choice to reside at Burswood Care.

Eligibility Criteria

- Resident aged 18+
- A diagnosed mental health condition
- History of severe mental health illness
- Impaired living and social skills meaning the person requires a supported living environment
- In receipt of a Disability Support Pension.

Referral Process

The process for assessment of referrals and potential admission into Burswood Care is listed in full below:

Process	
1	Individual visits Burwood Care to view facility and meet staff (preferred). Family and support people are encouraged to attend.
2	Completed Referral Form sent to Burswood Care Fax: (08) 9361 3907 or email to burswoodcare@roshana.com.au
3	Referral documentation sent to Bentley Mental Health for opinion on suitability.
4	Internal Assessment team reviews referral.
5	If **Referral declined**, the Referring Agency advised immediately
6	If **Referral accepted**, date of admission confirmed to all parties
9	If transition to hostel environment required, dates/times arranged.
10	All parties agree to work towards successful transition at all times.
11	**Where a trial unsuccessful** for undisclosed reasons or significant deterioration of mental health, Burswood Care will look to options ****

If any clarification or further information is required, please do not hesitate to contact Burswood Care staff.

Referral Form

The Hostel Referral Form as follows, ***must be completed in full*** prior to the applicant being admitted for the initial four-week trial period. It is understood that some of the information requested by the Hostel may not be available at the time of completion, or is not applicable. In this instance, a notation 'Not known' or 'Not applicable (N/A)" should be written in the relevant space.

Assessment of this referral will not occur until all relevant information is obtained and as such, you will be contacted and requested to provide this information if anything is missing or any further information is required. This will ensure that there is adequate planning for the delivery of care and support required for the new resident and safety is maintained for other residents and staff

Trial period

There is a mandatory requirement that all new Residents complete a ***four-week trial period***.

During this period, the Referring Agency is still responsible for the resident and in the event any unforeseen incident occurs which results in the resident not being suitable to reside at Burswood Care, we will contact you immediately to arrange an exit from the hostel. It is the responsibility of the Referring Agency to accept the resident back or arrange immediate alternative accommodation in the event the trial is not successful.

For those new residents coming from long-term hospital stays, we encourage the Referring Agency to plan and commence a Transition Plan into the hostel prior to admission. We believe this can alleviate high levels of anxiety at the change of accommodation and enables the new resident to begin to build new relationships with others and be familiar with their new surroundings in the hostel. In addition, we welcome input and visits from Family members and/or carers.

Admission

On the day of admission, an **Admission Pack** of documents will be provided to the new Resident, who will need to read and sign accordingly. These documents include:

- List of Resident's property and valuables;
- Authorization to release and/or obtain information from other agencies;
- Admission Policy
- Burswood Care rules, etc.

At time of admission, the Referral Agency and Resident must bring in the following:

- Four weeks medications (or 2 weeks + scripts);
- PRN medication (if required);
- Confirmation of payment for (2) weeks board and lodging fees + spending money for the trial period;
- Confirmation of the weekly/daily budget for the residents' spending money.

In addition, the Referral Agency must provide the following information if available:

If resident is leaving hospital:

- Care Transfer Summary;
- Pharmacy Notification Form (see page 8); and
- Discharge Summary must follow after the initial 4-week trial period.

If resident is coming from a community setting:

- Current mental health assessment and care plan; and
- Details of current medication.

Any other documentation which may assist the Hostel in understanding and assessing the individual. This can include:

- Risk information including information on PSOLIS alerts and/or detailed risk assessments;
- Any care plans, such as the current mental health care plan, Crisis Awareness Plan and/or Recovery plans;
- The Statewide Standardised Mental Health Assessment (SMHMR902);
- A detailed social and personal history.

It is important to note that some Residents may require a longer transition period, which will need agreement from all parties. This can be arranged prior to admission to the hostel.

For more information on referrals at Burswood Care, please contact:
Facility Manager
08 9472 4579
burswoodcare@roshana.com.au

General Information on Burswood Care Facility:

Address: 16 Duncan Street, Victoria Park, WA 6109
Phone: 08 9472 4579
Fax: 08 9361 3907
Licensee: Rosh Jalagge

APPLICANT INFORMATION AND PROFILE

FULL NAME: *PREFERRED NAME:* *ALIAS:* MARITAL STATUS: M ☐ D ☐ S ☐	DOB: PLACE OF BIRTH: ETHNICITY: GENDER: M ☐ F ☐ OTHER ☐
YEAR ARRIVED IN AUSTRALIA: PREVIOUS ADDRESS: RECENT ACCOMMODATION HISTORY:	REASON FOR LEAVING LAST ACCOMMODATION:
NEXT OF KIN OR GUARDIAN: ADDRESS:	RELATIONSHIP: PHONE NUMBER:
EMERGENCY CONTACT PERSON(S): 1. 2.	PHONE NUMBERS: 1. 2.
MEDICARE NBR: EXPIRY DATE: PRIVATE HEALTH INSURANCE: ☐ Yes ☐ No AMBULANCE COVER: ☐ Yes ☐ No	CENTRELINK/PENSION NBR: URN NBR: NAME & FUND NBR: NAME & FUND NBR:

PUBLIC TRUSTEE: ☐ Yes ☐ No Trustee Reference Number: TM Number: DVA: ☐ Yes ☐ No	Trust Managers Name: Contact PHONE NBR: NAME & PHONE NBR:
REFERRAL SOURCE/AGENCY: CONTACT PERSON:	ADDRESS: PHONE / FAX CONTACT: EMAIL ADDRESS:
GP: PSYCHIATRIST: ATTENDING OR TREATING PHYSICIAN: MENTAL HEALTH CLINIC: CASE MANAGER: ADVOCATE:	ADDRESS: PHONE: ADDRESS: PHONE: ADDRESS: PHONE: ADDRESS: PHONE: ADDRESS: PHONE: ADDRESS: PHONE:

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:
DENTIST:	ADDRESS & PHONE NBR:
ALLERGIES: *(Can be either <u>medication</u> or <u>food</u> allergies)*	CURRENT RISK OR GENERAL SAFETY ISSUES:
EDUCATION LEVEL: Left school before Yr 10 ☐ Yes ☐ No Basic level of education until Yr 10 ☐ Yes ☐ No Completed Year 12 ☐ Yes ☐ No	 Tertiary degree ☐ Yes ☐ No Trade or professional qualification ☐ Yes ☐ No Please name qualification:

BRIEF RISK ASSESSMENT

SOURCE OF INFORMATION:	☐ The Consumer	☐ Immediate carer (parent, spouse, child)
☐ Other informants (family, friends)	☐ Previous clinical records	☐ Assessing clinician's knowledge of consumer's past behavior/current clinical presentation
☐ Police / ambulance / other agencies	☐ Other (please specify)	

SUICIDALITY (Static historical) factors	Yes (1)	No (0)	Not known	**Dynamic (current) risk factor**	Yes (2)	No (0)	Not known
Previous attempt(s) on own life	☐	☐	☐	Expressing suicidal ideas	☐	☐	☐
Previous serious attempt	☐	☐	☐	Has plan / intent	☐	☐	☐
Family history of suicide	☐	☐	☐	Expresses high level of distress	☐	☐	☐
Major psychiatric diagnosis	☐	☐	☐	Hopelessness/perceived loss of coping or control over life	☐	☐	☐
Major physical disability/illness	☐	☐	☐	Recent significant life event	☐	☐	☐
Separated / Widowed / Divorced	☐	☐	☐	Reduced ability to control self	☐	☐	☐
Loss of job / retired	☐	☐	☐	Current misuse of drugs / alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe):*

LEVEL OF SUICIDE RISK (total score): ☐ **LOW (<7)** ☐ **MODERATE (7-14)** ☐ **HIGH (> 14)**

AGGRESSION / VIOLENCE Static (historical) factors	Yes (1)	No (0)	Not known	**Dynamic (current) risk factor**	Yes (2)	No (0)	Not known
Recent incidents of violence	☐	☐	☐	Expressing intent to harm others	☐	☐	☐
Previous use of weapons	☐	☐	☐	Access to available means	☐	☐	☐
Male	☐	☐	☐	Paranoid ideation about others	☐	☐	☐
Under 35 years old	☐	☐	☐	Violent command hallucinations	☐	☐	☐
Criminal history	☐	☐	☐	Anger, frustration or agitation	☐	☐	☐
Previous dangerous acts	☐	☐	☐	Preoccupation with violent ideas	☐	☐	☐
Childhood abuse	☐	☐	☐	Inappropriate sexual behavior	☐	☐	☐
Role instability	☐	☐	☐	Reduced ability to control self	☐	☐	☐
History of drug/alcohol misuse	☐	☐	☐	Current misuse of drugs/alcohol	☐	☐	☐

PROTECTIVE FACTORS *(describe):*

LEVEL OF VIOLENCE RISK (total score): ☐ **LOW (<7)** ☐ **MODERATE (7-14)** ☐ **HIGH (> 14)**

OTHER RISKS IDENTIFIED (AND RISK FACTORS)

RISK MANAGEMENT ISSUES (Please ensure alerts are noted here)

ADDITIONAL FORMS REQUIRED FOR REFERRAL:

Attach Pharmacy Notification Form	Attached?	☐ **Yes**	☐ **No**
Attach Care Transfer Summary	Attached?	☐ **Yes**	☐ **No**

CURRENT RESIDENT ASSESSMENT

Please complete the following assessment of the Resident, which will assist the Hostel in organizing the transition to be as smooth as possible ensuring continuity of care and minimizing any potential safety and risk issues.

Meals and Drinks

Resident competencies, degree of independence	*Nature of required staff assistance*
CHOKING RISK?: ☐ **Yes** ☐ **No**	

Personal Hygiene

Daily living activities	*Nature of required staff assistance*
Showering, bathing and washing	
Grooming, dressing, selecting clothing	
Skin care, finger and toenail care	
Brushing teeth/denture care	

Continence

Continence Status	*Continence Aids and regime*	*Nature of required staff assistance*
Urinary incontinence ☐ Yes ☐ No		
Faecal incontinence ☐ Yes ☐ No		
Catheter ☐ Yes ☐ No		
Stoma ☐ Yes ☐ No		

Mobility

Mobility Status and degree of independence	*Mobility aids required*	*Staff assistance required*
FALLS RISK?: ☐ **Yes** ☐ **No**	E.g. Walking stick, frame wheelchair	

Living Environment and Care of Possessions

Resident competencies and degree of independence	*Staff assistance required*
Cleaning of room and making/changing bed: Care of Personal Possessions:	

Current Medications

(Please include all prescribed and PRN medications)

Name of medication	*Dosage & frequency*	*Route of administration*	*Staff assistance and Resident compliance*
			(E.g. Self-administration, 1 to 1 with staff standby)

Challenging Behaviours

BEHAVIOUR	
Physical aggression ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Verbal aggression ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Intrusive behavior ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Emotional dependence ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Danger to self or others ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
BEHAVIOUR	
Inappropriate sexual Behavior /Vulnerability ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Sleep disturbances ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Alcohol, drugs or substance abuse ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:
Any other bizarre, risky or unusual behaviour ☐ Yes ☐ No	Nature: Frequency & last occurrence: Triggers & relapse signs: Management:

Communication, Literacy and Numeracy

Competency	*Nature of deficit and degree of independence*	*Staff assistance and aids required*
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		

Community Access

Competency	*Degree of independence and confidence*	*Staff assistance required*
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 neighbourhood shops, cafes and offices. ☐ Yes ☐ No		
Drives own car ☐ Yes ☐ No		
Prefers to walk everywhere ☐ Yes ☐ No		

Health

Competency	*Degree of independence and confidence*	*Staff assistance required*
Makes own appointments with doctor, dentist, podiatrist ☐ Yes ☐ No		
Attends doctor, dentist, podiatrist independently ☐ Yes ☐ No		
Attends health promotion activities or programs ☐ Yes ☐ No		

Current communicable or other disease

Disease	*Management and treatment*	*Staff assistance required*
Diabetes ☐ Yes ☐ No		
Hepatitis ☐ Yes ☐ No		
HIV ☐ Yes ☐ No		
Other communicable disease, infectious condition or chronic disease ☐ Yes ☐ No		

Special Interventions required

Intervention	*Management and treatment*	*Staff assistance required*
Blood sugar monitoring ☐ Yes ☐ No		
Administration of Insulin ☐ Yes ☐ No		
Stoma care ☐ Yes ☐ No		
Weight monitoring ☐ Yes ☐ No		
Nebuliser ☐ Yes ☐ No		
Other:		

Immunisation

Please advise whether Resident has current vaccination status *E.g. COVID-19, Polio, Tetanus/Diphtheria, Measles, Mumps, Whooping cough, Hepatitis A and B, Influenza, Meningococcus C, Pneumococcus, Rubella*

Disease	*Immunisation Status*
Covid-19	*First dose (date):* *Second dose (date):* *Booster (date):*

Mental Health

BEHAVIOUR & SYMPTOMS	
Delusions ☐ Yes ☐ No	Type & description:
	Frequency & last occurrence:
	Triggers & signs of relapse:
	Management:
Hallucinations ☐ Yes ☐ No	Type & description:
	Frequency & last occurrence:
	Triggers & signs of relapse:
	Management:
Anxiety and Fearfulness ☐ Yes ☐ No	Type & description:
	Frequency & last occurrence:
	Triggers & signs of relapse:
	Management:

Mental Health

Is there a current Crisis Management Plan in place? ☐ Yes ☐ No	Provide details or attach a copy to this referral.

Psycho-Social

Please comment on the following:

Relationship with family and friends?	
Links and personal networks?	Contact/s & details:
Involvement in activities, internal or external to their previous accommodation, workshops, OT programs, day centres, etc?	Contact/s & details:
Choice and/or potential to transition to independent living in the future?	
Identified special interests or talents?	
Any known personal goals?	

Financial Management

Competencies and financial information	*Assistance required* *e.g. Staff, Public Trustee, Centrelink, Family member, Friend*
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	
Type of Benefit: (e.g, DSP) Enter benefit type:	Income per fortnight: Enter income amount

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 Burswood 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 Burswood Care. I acknowledge that the staff at Burswood Care may contact mental health professionals named on this form, to discuss personal information about myself. I give permission for the staff at Burswood 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 Burswood Care.

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. Do not hesitate to contact Burswood Care if you have any queries.

Management
Burswood Care