ENHANCED ADULT COMMUNITY LIVING SUPPORTS (CLS) NORTHERN SYDNEY: REFERRAL FORM

ELIGIBILITY CRITERIA: Applicants will be eligible for CLS Support if:

- ☐ Aged 16 Years or older
- ☐ Has a desire to engage with the program
- ☐ Engaged with Clinical Case Management
- ☐ Diagnosed with severe mental illness or distress
- ☐ Living in the geographical area of Northern Sydney
- ☐ Does not receive support through a nursing home or aged care facility

If the applicant does not have current case management, please refer him/her to their local Mental Health Team by calling 1800 011 511

Section One: APPLICANT DETAILS

First Name:	**Last Name:**
Telephone:	**Mobile:**
Gender:	**Date of Birth:**
Address:	**Postcode:**
State:	**MRN:**

Permanent Australian Resident?

☐ Yes ☐ No Country Of Birth: .....

Does the applicant identify as being a refugee?

☐ Yes ☐ No

Does the applicant identify as being CALD?

☐ Yes ☐ No

Is an interpreter required?

☐ Yes ☐ No Language Spoken: .....

Does the Applicant Identify As:

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander

Housing Status:

- ☐ Public Housing
- ☐ Social Housing Aboriginal
- ☐ Community Housing
- ☐ Emergency Housing
- ☐ Private Rental
- ☐ Boarding House
- ☐ Owned Home
- ☐ Homeless
- ☐ Correctional Facility: .....
- ☐ Hospital: .....

NDIS Involvement?

☐ Yes ☐ No

Details: .....

Living Arrangement:

☐ Lives with partner
☐ Lives with children
☐ Lives with other family
☐ Lives with others - not family
☐ Lives alone

Employment Status:

☐ Full-time employment
☐ Part-time employment
☐ Unemployed
☐ Retired
☐ Casual employment
☐ Supported employment

Receiving a pension?

☐ Yes ☐ No

Pension Type: .....

CRN: .....

Community Treatment Order?

☐ Yes ☐ No

Details: .....

Forensic Treatment Order?

☐ Yes ☐ No

Details: .....

Public or Appointed Guardian?

☐ Yes ☐ No

Details: .....

Section 2: HEALTH INFORMATION

Please list details of primary mental/physical health diagnoses and any other conditions that impact on the applicant's wellbeing:

Most recent hospital admissions:

Hospital & Ward	**Duration (including dates)**:	**Comments**

Medication Information (*please print)*

Medication	**Frequency**	**Dosage**	**Comments**

Tick any substances that the applicant uses regularly:

☐ Alcohol ☐ Nicotine/Tobacco

☐ Other Substances: .....

Does the applicant have any allergies?

☐ Yes ☐ No Details: .....

Section 3: REASONS FOR REFERRAL

How can Community Living Services Support the applicant's recovery?

- ☐ Learning new skills
- ☐ Nicotine, alcohol or other drug cessation
- ☐ Building a support network
- ☐ Learning self-care
- ☐ Building/Maintaining social connections
- ☐ Finding employment
- ☐ Other goals, please specify below:
- ☐ Self-advocacy skills
- ☐ Travel training
- ☐ Remembering medication
- ☐ Remembering appointments
- ☐ Linking with professional services
- ☐ Supporting daily living skills

Section 4: SAFETY CONSIDERATIONS: *Please note these are not exclusion criteria*

Suicide and/or self-harm? ☐ Yes ☐ No

Details:

Forensic History? ☐ Yes ☐ No

Details:

Past physical or verbal aggression? ☐ Yes ☐ No

Details:

At risk of homelessness? ☐ Yes ☐ No

Details:

Risk taking and/or impulsive behaviour? ☐ Yes ☐ No

Details:

Section 5: ADDITIONAL INFORMATION

Please outline any additional information, history, or anything else you or the applicant would like to add:

Section 6: CASE MANAGEMENT AND CURRENT SUPPORT DETAILS

Case Management:

Case Manager Name: .....

Team/Organisation: ..... Contact Number: .....

Email: .....

Please list details of other medical professionals and other services/supports involved.

Name	Service/Organisation	Role	Contact Details

Section 7: APPLICANT CONSENT: *This section must be signed*

I, ... give my consent to Parramatta Mission to seek/share information with the referrer for the period of this intake process, concerning matters relating to this application. I also consent to Parramatta Mission to keep a record of my referral.

I agree to allow Parramatta Mission staff to contact me in order to update my information and to see if I am still interested in the program.

I consent to Parramatta Mission sharing my application with HASI Providers in the Northern Sydney Region should they be better able to accommodate my referral at this time.

Applicant's Name: .....

Applicant Signed: .....

Date: .....

Section 8: REFERRING AGENT DETAILS

Referring Agent Name: .....

Service/Organisation: ..... Role/Relationship: .....

Telephone: ..... Mobile: .....

Email: .....

Please include most recent mental health review document or risk assessment.

All referrals or enquiries to be emailed to: clsns@parramattamission.org.au

The referring agent and applicant will be contacted within 3 business days after receipt of the referral.

Office Use Only

Recieved:	Entered:	Actioned: