Supported Transitional Housing Program – Referral Form

Section 1: Participant Details

Participant's Name ______________________ Preferred Name ______________

Date of Birth ______________________ Gender Identity ______________

Email Address ______________________ Phone Number ______________

Current Address ____

Country of Birth ______________________ Language at Home ______________

Cultural Identity ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous ☐ Not Stated

Aboriginal and/or Torres Strait Islander land, country or group ______________________

Citizenship ☐ Australian Citizen ☐ Permanent Resident ☐ Other

Interpreter Required? ☐ No ☐ Yes If yes, which language? ______________________

Community Management Order, (or other Order) in Place? ☐ No ☐ Yes

Income Source ____

____

Centrelink Reference Number ____

Date from which housing is required ____

Trustee in Place? ☐ No ☐ Yes *Name & Phone Number:* ______________________

Public Guardian in Place? ☐ No ☐ Yes *Name & Phone Number:* ______________________

Carer in Place? ☐ No ☐ Yes *Name & Phone Number:* ______________________

Case Manager in Place? ☐ No ☐ Yes *Name & Phone Number:* ______________________

Other Services Engaged ☐ No ☐ Yes *Name & Phone Number:* ______________________

Parole Officer Details (if applicable) *Name & Phone Number:* ______________________

Name & Phone Number: ______________________

Emergency Contact/Next of Kin *Details & Relationship:* ______________________

Preferred method of contact ☐ Email ☐ Text ☐Call ______________________

The program accepts people with and without history of incarceration. Please indicate which applies:

☐ Has or will be exiting corrections custody
☐ No history of incarceration

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Section 2: Supports

NDIS Plan in Place? ☐ No ☐ Yes *Plan Number:*

NDIS Coordinator of Supports *(name/contact)* ____________________

Accessed TeamHEALTH Supports Previously? ☐ No ☐ Yes *List Services and Dates:* ____________________

____

Current Psychiatric Medications

☐ No ☐ Yes

If yes, please attach medication chart to this referral.

Physical Health Conditions

Any physical health conditions, including infectious disease? ☐ No ☐ Yes, List:

Physical Health Medication

☐ No ☐ Yes

If yes, please attach medication chart to this referral.

Are they independent in activities of daily living (ADL)? ☐ Yes ☐ No

If no, please complete below - Requires assistance with:

Section 3: Referrer Details

Referring Organisation/Worker *(name/contact)* ____________________

Contact Number ____________________

Email ____________________

Date of Referral ____________________

Section 4: Eligibility Screening

The program is available for people meeting the below **two** criteria:

☐ At risk of or experiencing homelessness

☐ 18+ Years of age

Section 5: Supporting Documents

Photo ID of participant (if available) ☐ Yes ☐ No

Existing support plan (if available). ☐ Yes ☐ No

TeamHEALTH staff located on site may be available to assist with elements of this plan (for example assisting with appointments, referrals etc).

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Section 6: Risk Assessment (Referrer to complete)		
Participant risk factors *if selecting yes to any of the below please expand on or attach relevant information/documentation prior to completion of the referral*	Yes	No
History of suicide attempt/s or current suicide ideation (e.g. chronic, recent)	☐	☐
Please provide further details:		
History of self-harm (e.g. chronic, recent)	☐	☐
Please provide further details:		
Recent traumatic life event (e.g assault, bereavement, legal concerns, family violence, homelessness etc).	☐	☐
Please provide further details:		
Historical or current drugs or alcohol use	☐	☐
If yes, please provide details of substances and any history of rehab or AOD counselling:		
Forensic history (including DVO, custodial orders, recent incarceration, upcoming legal matters, parole or bail conditions)	☐	☐
Please provide further details including most recent offences and most serious offences:		
Recent incident involving aggression/violence/weapon use or possession	☐	☐
Please provide further details:		
Expressing intent to harm others/ Preoccupation/hallucinations with violent or paranoid themes/ideas	☐	☐
Please provide further details:		

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Section 6: Risk Assessment (Referrer to complete)

Inappropriate sexual behaviour	☐	☐
Please list serious events or presenting behaviours:		
Reduced ability to self-control / difficulties with emotional regulation etc.	☐	☐
Please provide further details:		
Known prejudices – ethnic, religious, (including prejudices that emerge as part of psychosis)	☐	☐
Please provide further details:		
Vulnerabilities (financial abuse, trauma history, relational/sexual)	☐	☐
Please provide further details:		

Protective factors (e.g. friends, family, professional relationships, culture, faith, hobbies, study, employment etc.)

Recommendations to support the safety and comfort of the person in our service (e.g. safety plans, coping strategies, skills or strengths)

Other Support Needs/Additional Notes:

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Section 7: Consent

I consent to this referral/verbal consent has been gained to complete this referral. I understand that this information will be stored on the TeamHEALTH system and that my details will be de-identified if they are used in reporting. I give permission for TeamHEALTH to discuss this information for the purposes of establishing and receiving supports.

TeamHEALTH uses personal information to assist in the coordination and provision of services. Individuals are not required by law to provide this information or consent to this proposed use and disclosure of information. The information provided to TeamHEALTH will be stored in accordance with the Australian Privacy Principles established under the Privacy Act 1998 (Commonwealth) and Northern Territory of Australia Information Act.

Signature of Participant	Signature of Public Guardian (if applicable)	Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Completing this Form

- Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form or to discuss eligibility.
- Send the completed form to: **teamhealth@teamhealth.asn.au**
- TeamHEALTH will contact the participant or Public Guardian within two working days of receiving this form.

Thank you for your Referral

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