Azalea care referral Form

Source of referral:

Name:	**Phone**:
Agency:	
Email address:	

Do the participants have a case manager at the Local Health District Service?

☐ Yes	☐ No
Name:	Team:
Contact number:	
Email address:	
Is the participant willing to engage with Azalea?	☐ Yes ☐ No

Participant details:

First name/s:	Last name:
Address:	Postcode:
Telephone:	Mobile:
Date of birth:	Gender:
Country of birth:	Languages spoken:
CALD / ATSI:	Interpreter/cultural liaison officer required: ☐ Yes ☐ No
Employed: ☐ Yes ☐ No	Employment type:
Pension: ☐ Yes ☐ No	Pension type:

NDIS:

Do you have a NDIS plan? ☐ Yes ☐ No

If yes, please provide the following details.

NDIS number:	
Start date of plan:	End date of plan:
Is your NDIS plan managed by someone else? ☐ Yes ☐ No	
If successful in accessing this service, is funding included in your plan?	

NDIS continued:

What are your NDIS goals as per your plan?

1.

2.

3.

4.

5.

Are you aware of who your Local Area Coordinator is?

How many days a week and what activities would you like to do with our program?

Support details:

Does the participant have a nominated carer? ☐ Yes ☐ No

Relationship to participant:

Next of kin details:

Name:

Phone number:

Relationship:

Does the participant have pets? ☐ Yes ☐ No

If yes, what kind:

Does the participant have children? ☐ Yes ☐ No

If yes, do they live with you? ☐ Yes ☐ No

Ages:

Support details continued:

GP:

Name of person: | Phone number:

Name of organization:

Address:

Psychiatrist:

Name of person: | Phone number:

Name of organization:

Address:

Psychologist:

Name of person: | Phone number:

Name of organization:

Address:

Social worker:

Name of person: | Phone number:

Name of organization:

Address:

Other health provider:

Name of person: | Phone number:

Name of organization:

Address:

Other agencies currently involved, including service they provide:

Health and functional information:

Does the participant have a diagnosed mental illness? ☐ Yes ☐ No

Primary diagnosis

☐ Schizophrenia	☐ Eating disorder
☐ Bipolar disorder	☐ Post-natal depression
☐ Depression	☐ Schizo-affective
☐ Anxiety	☐ Other diagnosis:
☐ Personality disorder	☐ Not known

Secondary diagnosis:

Allergies:

Other medical conditions:

Current medications:

Brief history:

Health and functional information continued:

Financial management issues:	☐ Yes	☐ No
Behavior concerns:	☐ Yes	☐ No
Forensic history:	☐ Yes	☐ No
CTO in place:	☐ Yes	☐ No
Substance abuse:	☐ Yes	☐ No
Self-harm:	☐ Yes	☐ No
Suicide attempts:	☐ Yes	☐ No
Current suicide ideation:	☐ Yes	☐ No
Violence and aggression:	☐ Yes	☐ No
Risk-taking behaviors	☐ Yes	☐ No

Are there any risks we should be aware of when working with this person, current or historical? ☐ Yes ☐ No

Please detail:

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE ATTACH ALL RELEVANT INFORMATION TO REFERRAL FORM

Supporting information attached

Please attach a current copy of the medication regime, and a history of psychiatric admissions.

Attached:	☐ Yes	☐ No

Please ensure recently completed, relevant, standardised assessment tools, measurement tools and discharge summaries are attached at the time of referral.

Has the participant been involved in completing this form?	☐ Yes	☐ No

* The Privacy Act requires the participant to sign this form giving their consent for the release of their information and details.
* Current risk assessment must be provided

(If there is no current risk assessment, please contact Azalea Care)

CONSENT:

I give my consent to the Azalea care to seek/share information with the following people concerning matters related to this application:

- ☐ Local Health District(Hospitals or local Community Health Teams)
- ☐ Medical service (GP)/ Health professionals
- ☐ Housing provider
- ☐ Other non-government organisations
- ☐ De-identified statistics for program evaluation
- ☐ NDIS / NDIA including Local Area Coordinator
- ☐ Other:

I also give my consent to Azalea Care to keep a record of my referral. I understand that this information will be coded to protect my identity and will only be accessible to the services that I come into contact with.

I agree to allow Azalea Care staff to call me (or my designated contact person if I am not contactable) in order to update my information and to see if I am still interested in Azalea.

Signed:

Print name: Date:

The referrer agrees that all information submitted in this referral is an accurate reflection of the client's support needs, is correct with no information withheld, and is necessary for Azalea care to fulfil its duty of care to clients, employees and other partner agencies.

REFERRER'S NAME (PRINT):

DESIGNATION:

REFERRER'S SIGNATURE: DATE:

AZALEA CARE
Hope, Recovery, Well-being