|  |  |
| --- | --- |
| Referral to **hiv supported accommodation** |  ADAHPS_COLOUR_byline_SMALL**NSW HIV SUPPORTED ACCOMMODATION** |
| **DATE of referral** | **client NAME** **CURRENT**  **ALIAS**   |
|

|  |  |
| --- | --- |
| **DOB** | **GENDER** |
|  |  |
| **centrelink benefit TYPE** |
|  |
| **Medicare Number** |
|  |
| **T-NUMBER PATHWAYS** |
|  |
| **pathways status**  |
|  |
| **AREA PREFERENCE** |
|  |

 |

|  |
| --- |
| **client ADDRESS current** |
|  |
|  |
| **client ADDRESS previous** |
|  |
|  |
| **PHONE**   |
| **CURRENT HOUSING SITUATION** [ ]  No permanent accommodation[ ]  Tenancy / sharing (rental, owner)[ ]  Supported (aged care, AOD, HIV etc)[ ]  Other (clarify) |

 |

|  |  |
| --- | --- |
| **identify as:** ABORIGINAL  | [ ]  **yes** [ ]  **no** |
| Torres Straight Islander | [ ]  **yes** [ ]  **no** |
| If yes, would they like an Aboriginal Health Worker? | [ ]  **yes** [ ]  **no** |
| **COUNTRY OF BIRTH** [ ]  Australia [ ]  \_\_\_\_\_\_\_\_\_\_\_\_ |
| **PREFERRED LANGUAGE** | [ ]  English  |
| [ ]  Other \_\_\_\_\_\_\_\_\_\_\_ |
| **interpreter required** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Is the client aware of the referral?** [ ]  **yes** [ ]  **no** If not, why? |
| ELIGIBILITY CRITERIA (select / HIGHLIGHT one or more)[ ]  NSW Resident[ ]  HIV Positive[ ]  Accepted onto Housing Pathways waiting list[ ]  Case managed / referred for case management[ ]  HIV related brain impairment (e.g. HAND, HAD, PML)[ ]  HIV related complex needs which prevent independent living

|  |  |
| --- | --- |
| **GUARDIAN TYPE & NAME** |  |
| **FINANCIAL MANAGEMENT** |  |
| **LEGAL ORDER** |  |
| **PROBATION / PAROLE** |  |
| **HIV TREATING FACILITY** |  |
| **HIV TREATING PHYSICIAN** |  |
| **GP** |  |
| **PSYCHIATRIST** |  |
| **PSYCHOLOGIST** |  |
| **OCCUPATIONAL THERAPIST** |  |
| **DRUG SUPPORT** |  |
| **NGO SUPPORT** |  |
| **OTHER** |  |

 | **HOUSING NEED (select one or more)**🞎 Short term respite & stabilisation 🞎 Medium to long term 🞎 Live alone with support 🞎 Shared living with support**SUPPORT REQUIREMENT**🞎 Psychosocial support🞎 Nursing care**HIV HEALTH**

|  |  |
| --- | --- |
| Date 1st diagnosed |  |
| Date of latest test  |  |
| Viral load |  |
| CD4 count  |  |

|  |  |
| --- | --- |
| **NOK NAME** |  |
| **RELATIONSHIP** |  |
| **CONTACT DETAILS** |  |

 |
| **BRIEF SUMMARY - CURRENT SITUATION AND ACCOMMODATION NEED OF CLIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **name of REFERRER**  |  | **agency** |  |
| **ROLE** |  | **CONTACT** |  |

 |

**Complete ALL sections & email to** jo.spengeler@health.nsw.gov.au  **v 2019**