|  |  |  |  |
| --- | --- | --- | --- |
| 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](mailto:jo.spengeler@health.nsw.gov.au)  **v 2019**