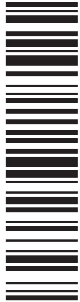
Health
South Eastern Sydney
Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL (Stanford, Transitional & Villa)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE



SES010204

When complete email to: SESLHD-Adahps-ClinicalInformation@health.nsw.gov.au

Date of Referral:	Is the client aware of the referral? ☐ Yes *(Client must be aware and in agreement)*

CLIENT DETAILS

Alias:

Sex at birth: ☐ Male ☐ Female ☐ Intersex ☐ Unknown Gender:

Country of Birth:	Phone:

Previous Street address:

State Postcode

Current housing situation:
☐ No permanent accommodation ☐ Tenancy/sharing (rental, owner)
☐ Supported (Aged Care, AOD, HIV, etc) ☐ Other (Specify):

Preferred language	Interpreter required? ☐ Yes ☐ No

Aboriginal and/or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Decline to respond ☐ Unknown
If yes → ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both

Medicare Number:	Valid to:

Centrelink Benefit Type:

T-Number Pathways:	Pathways Status:

Area Preference:

Alternative Person to Contact:

Relationship:	Contact details:

ELIGIBILITY CRITERIA

☐ NSW Resident
☐ Accepted onto Housing Pathways waiting list
☐ HIV related brain impairment (e.g HAND, PML)
☐ HIV Positive
☐ Case managed/Referred for case management
☐ HIV related complex needs which prevent independent living

HEALTH

Date first diagnosed with HIV:	Date of latest test:
Viral load:	CD4 count:

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

S1152 141220

SUPPORTED ACCOMMODATION REFERRAL (Stanford, Transitional & Villa)

SES010.204

DO NOT PRINT

NO WRITING

Health
South Eastern Sydney
Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL (Stanford, Transitional & Villa)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / ________	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

HOUSING NEED (select one or more)

☐ Short term respite and stabilisation
☐ Live alone with support
☐ Medium to long term
☐ Shared living with support

Support requirement: ☐ Psychosocial ☐ Nursing Care

OTHER

Guardian type and name:

Financial Management:

Legal Order:

Probation/Parole:

HIV treating facility:

HIV treating physician:

GP:

Psychiatrist:

Psychologist:

Occupational Therapist:

Drug Support:

NGO Support:

Other:

SUMMARY

Brief summary of current situation and accommodation need of client

REFERRER DETAILS

Name: Organisation:

Address:

State: Postcode: Phone:

Email:

DO NOT PRINT

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

SES010204

NO WRITING