South Eastern Sydney
Local Health District

Facility:

REFERRAL FOR BROKERAGE

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010428

Email to: SESLHD-ABC@health.nsw.gov.au

REFERRER DETAILS

Date of Referral:	Referrer's Name:	Service:

CLIENT DETAILS

Phone:	Local Health District (LHD) (if known):
Centerlink: ☐ No ☐ Yes CRN:	Medicate Number: ☐ None

ELIGIBILITY

a) Residents of: Central Coast, Hunter New England, Illawarra Shoalhaven, Mid North Coast, Northern NSW, Northern Sydney, Nepean Blue Mountains, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney LHDs:

- Has moderate to severe HAND (HIV-associated Neurocognitive Disorder) or other HIV-related cognitive impairment (such as PML or Cerebral Toxoplasmosis) ☐ Yes ☐ No
- Has significant functional impact related to HIV ☐ Yes ☐ No
- Has a case manager ☐ Yes ☐ No

b) Residents of: Far West NSW, Southern NSW, Murrumbidgee and Western NSW LHDs

- Has HIV and co-morbidities ☐ Yes ☐ No
- Has complex psychosocial issues ☐ Yes ☐ No

HIV BLOOD RESULTS

Viral load:	Date:	CD4 Count:	Date:

Neuropsychological assessment completed? ☐ Yes ☐ No ☐ Unknown

FUNDING

Has the individual applied for or are they receiving other funding?

ACAT ☐ Yes ☐ No ☐ N/A ☐ Approved Application Number: ______________________

NDIS ☐ Yes ☐ No ☐ N/A ☐ Approved NDIS Number: ______________________

COMPACKS ☐ Yes ☐ No ☐ N/A ☐ Approved Participant Number: ______________________

Other:

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

S1140A 070923

REFERRAL FOR BROKERAGE

SES010.428

South Eastern Sydney
Local Health District

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REFERRAL FOR BROKERAGE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / _______	M.O.
ADDRESS	
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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ASSISTANCE REQUIRED

Tick all that apply. (Descriptions below)

☐ Personal care
☐ Domestic assistance
☐ Community access
☐ Medication adherence
☐ Shopping
☐ Meal preparation
☐ Respite for carer
☐ Transportation
☐ Incentives
☐ One off assistance

Intended outcome: ____

____

When is the service / health incentive required? Note. It can take 2-3 weeks to arrange services. Start date:

Incentive type: ☐ Grocery ☐ Fuel ☐ Other Details:
Suggested value: ☐ $10 ☐ $20 ☐ $50 ☐ $100 Cards/wk: No. wks:

Brokerage: Hours / wks:

Time required (insert into the table below): Frequency: ☐ Once ☐ Ongoing

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Referrer's Signature: Date:

BROKERAGE SERVICES FUNDED BY ADAHPS

Personal care Supervision and physical assistance with: showering, bathing / personal hygiene, dressing and undressing using dressing aids.

Domestic assistance Prompting and assistance with household duties.

Medication Prompting for medication adherence, assisting in collection of medication from pharmacy. Includes positive reinforcement.

Shopping Assistance with transport to shops, individual attention, support and/or physical assistance with shopping for personal items and groceries.

Community access Travel training; encouragement and support to take part in social and community activities that promote and protect the client's lifestyle, interests and wellbeing.

Transportation Limited to medical appointments.

Meal preparation Assistance, as necessary, in preparing meals and special diets for healthy living. Preparing and storing food.

Respite Ensuring carer is supported and provided with regular breaks, taking client out of home or staying in with client while their carer goes out.

One-off assistance Can be considered on a case by case basis.

Health Incentives Grocery and fuel cards can be issued to encourage client to engage with services / attend medical appointments, fuel / transport to access appointments.

REVIEW OF APPLICATION (OFFICE USE ONLY)

Approved? ☐ Yes ☐ No *If no → reason:*

Adahps Co-ordinator Name: Adahps Co-ordinator Signature:

Date:

Agency: Cost per week: $

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2019

NO WRITING