South Eastern Sydney Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL - MEDICAL (Yaralla)

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

When completed email to: seslhd-abc@health.nsw.gov.au

Name of Referrer: Date of Referral:

CLIENT INFORMATION

Phone Number:

Sex: ☐ Male ☐ Female ☐ Inderterminate ☐ Unknown ☐ Not specified

Gender: ☐ Male ☐ Female ☐ Non Binary ☐ Gender Non-Conforming ☐ Prefer not to say

HEALTH INFORMATION

Does the client suffer from pain? ☐ Yes ☐ No *if Yes → Details:*

Allergies:

Diagnosis:

Fatigue:

Other medical conditions:

VISION AND HEARING

Does the client have a visual impairment? ☐ Yes ☐ No if *Yes* → Are glasses or contact lenses worn? ☐ Yes ☐ No

Does the client have a hearing impairment? ☐ Yes ☐ No if *Yes* → Is a hearing aid used? ☐ Yes ☐ No

Any other visual or hearing aids used? ☐ Yes ☐ No if *Yes* → Details

MOBILITY

Is the client able to physically walk up and down the stairs at Yaralla (there are about 22 stairs to upstairs bedrooms)? ☐ Yes ☐ No

Does the client have enough impulse control to wait for staff assistance if necessary? ☐ Yes ☐ No

Have there been falls in the last 6 months? ☐ Yes ☐ No

if *Yes* → Details:

South Eastern Sydney Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL - MEDICAL (Yaralla)

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ACTIVITIES OF DAILY LIVING

Is assistance required with:
Toileting? ☐ Yes ☐ No if *Yes* → Details:

Continent of Urine?	☐ Yes ☐ No	Continent of Faeces?	☐ Yes ☐ No
Are pads or other continence aids used?	☐ Yes ☐ No	Issues with constipation?	☐ Yes ☐ No
Issues with diarrhoea?	☐ Yes ☐ No		

If bowel accidents occur, how often per day/week?

Showering? ☐ Yes ☐ No if *Yes* → Details:

Feeding? ☐ Yes ☐ No if *Yes* → Details:

Domestic duties? ☐ Yes ☐ No if *Yes* → Details:

Does the patient have any:
Swallowing difficulties? ☐ Yes ☐ No if *Yes* → Details:

Special dietary needs? ☐ Yes ☐ No if *Yes* → Details:

EMPLOYMENT & LEISURE INTERESTS

When was the client last employed?

What type of work was it?

What other types of work has the client been involved with?

What leisure interests does the client have?

SOCIAL, BEHAVIOURAL AND CULTURAL ISSUES

The client displays behaviour that is:
☐ Impulsive ☐ Repetitive ☐ Aggressive ☐ Labile
☐ Lacking in motivation ☐ Apathetic ☐ Defensive when assessed or reoriented

The client:
☐ Has poor concentration ☐ Lacks initiative ☐ Has memory difficulty
☐ Has poor decision making skills ☐ Gets distracted easily

Does the client have insight into their cognitive condition? ☐ Yes ☐ No

Does the client smoke cigarettes or use a vape? ☐ Yes ☐ No
if *Yes* → Advise client they need to engage in a smoking cessation Program and/or Nicotine Replacement Therapy

Any cultural issues we should know about that impact on the client's daily life?

NO WRITING

South Eastern Sydney Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL - MEDICAL (Yaralla)

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010203

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

GUARDIAN

Name:

Address:

State:	Postcode:	Phone:

Email:

FINANCIAL MANGEMENT

Name:

Address:

State:	Postcode:	Phone:

Email:

WEEKLY COST

Contact Supported Accommodation Co-ordinator for current costs. Ph 3982 8600

OTHER MEDICAL / HEALTH PROFESSIONALS

Name	Role	Organisation	Phone

ATTATCHMENTS

Attach as many of these documents as applicable to this form – attachments assist the panel in making an informed decision about the client's priority need and suitability.

- ☐ Neuropsychological Assessment
- ☐ Full medication list (incl. dose and times)
- ☐ Hospital Discharge Summary
- ☐ Latest Pathology (HIV Results)
- ☐ Health Summary
- ☐ Nursing Care Plan
- ☐ Speech Pathology Report
- ☐ Physiotherapy Report
- ☐ Occupational Therapy Report

South Eastern Sydney
Local Health District

Facility: Adahps

SUPPORTED ACCOMMODATION REFERRAL - MEDICAL (Yaralla)

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE