



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

**REFERRAL FOR
BROKERAGE**

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):
Centrelink: <input type="checkbox"/> No <input type="checkbox"/> Yes CRN:	Medicare Number: <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:



SES010428

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

S1140A 070923

REFERRAL FOR BROKERAGE

SES010.428



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

Facility:

**REFERRAL FOR
BROKERAGE**

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ASSISTANCE REQUIRED

Tick all that apply. (Descriptions below)

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

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: \$ _____

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

