GUIDELINES FOR REFERRALS TO ICLA RESIDENTIAL FACILITIES

1. Applicants must have a major psychiatric disability.
2. Preference will usually be given to applicants who reside in the eastern suburbs or inner city area.
3. Application forms are required to be completed by the referring agency.
4. Release of Information should be signed by the applicant prior to acceptance as a resident.
5. Include in the referral
   a. A letter of support from treating Psychiatrist
   b. A completed Occupational Therapist Assessment if in hospital
6. Applicants will be interviewed and assessed for suitability of a vacancy. No guarantee of service can be given.
7. Applications will only be accepted on the application form provided. The application form may be faxed or emailed to enable processing, however the original application must be posted or delivered to ICLA.
8. Please return this application to:

The Operations Manager
ICLA
PO Box K305
Haymarket NSW 1240

Or

The Operations Manager
ICLA
Suite 76, Level 7,
8-24 Kippax Street
Surry Hills NSW 2010

Name of Applicant: ....

PARTICULARS

Given Name: ....

Present Address: ....

Present Phone Number: .... Date of Birth: ....

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married/Defacto

Income: ☐ Disability Support Pension ☐ Job Search Allowance
☐ Aged Pension ☐ Sickness Benefit
☐ Open Employment ☐ Other

Medicare Number .... Pension Number ....

Are the applicant's affairs under the control of the Protective Office? ☐ Yes ☐ No

Are the applicant's affairs under the control of a Guardian? ☐ Yes ☐ No

Who is the Guardian? ☐ Public Guardian ☐ Other (specify)..

Is the client under a Community Treatment Order or similar? ☐ Yes ☐ No

Does the applicant have a case manager? ☐ Yes ☐ No

Is the applicant's first language English? ☐ Yes ☐ No

If no, what language? .... Ethnicity ....

Is an interpreter required? ☐ Yes ☐ No

Can the applicant read English?

☐ With great difficulty ☐ with some difficulty ☐ with no difficulty

Can the applicant write English?

☐ With great difficulty ☐ with some difficulty ☐ with no difficulty

Comments: ....

....

REFERRAL SOURCE

Name.. Position...

How long has the referrer known the applicant? ....

Agency...

Address...

....

Telephone ....Fax... . E-mail: ....

MEDICAL

Psychiatric diagnosis: ....

....

Current Medications: ....

....

....

....

....

Medication compliance history, including current: ....

....

....

Signs and symptoms of mental health deterioration (i.e. suspicious, isolative, insomnia etc.): ....

....

....

Last 3 Psychiatric Admissions:

Dates: From..........................To.......................... Place: ....

Dates: From..........................To.......................... Place: ....

Dates: From..........................To.......................... Place: ....

General Health Status:

☐Diabetes ☐Memory Loss ☐Epilepsy ☐ Asthma ☐Gastro Intestinal

Other (specify)..

Is the applicant taking any medication for the above? ☐Yes ☐No

(Specify)..

Does the applicant have any communicable diseases? ☐Yes ☐No

(Specify)..

Does the applicant have any special dietary requirements? ☐Yes ☐No

(Specify)..

Does the applicant suffer from any allergies? ☐Yes ☐No

(Specify)..

Is the applicant a tobacco smoker? ☐Yes ☐No if yes, specify how many daily.........................

Does the client abuse alcohol? ☐Yes ☐No

(Detail)..

Does the client use non-prescribed / illicit drugs? ☐Yes ☐No

(Detail)..

....

Is there any indication of abuse of other medications? ☐Yes ☐No

(Detail)..

....

MEDICAL (continued)

Medication Compliance ☐ Good ☐ Average ☐ Poor

....

....

Does the applicant abuse their prescribed medications? ☐ Yes ☐ No

(Detail)..

....

Significant behavioural problems: (give details)

☐ Suicidal tendencies...

....

☐ Physical aggression self...

....

☐ Intrusive sexual behaviour..

....

☐ Verbal aggression..

....

☐ Absconding..

....

☐ Physical aggression to others..

....

☐ Difficulty handling financial affairs..

....

☐ Gambling (please give details)..

....

☐ Other (give details)..

Please list health professionals involved in the care of the applicant:

Case Manager.. Ph: ....

Psychiatrist... Ph: ....

General Practitioner.. Ph: ....

Medical Specialist... Ph: ....

Other.. Ph: ....

Other.. Ph: ....

SOCIAL INTERACTION

Is the applicant's interaction with their family: ☐ Frequent ☐ Infrequent ☐ Not at all

Is the applicant's interaction with friends: ☐ Frequent ☐ Infrequent ☐ Not at all

Is the applicant's family supportive: ☐ Yes ☐ No

Details...

Does the applicant:

Have a tendency to isolate themselves from others ☐ Yes ☐ No

Details...

Have an existing network or friends ☐ Yes ☐ No

Details...

Use recreational community facilities ☐ Yes ☐ No

Details...

Have conversation skills ☐ Yes ☐ No

Details...

Have the ability to participate in group situations ☐ Yes ☐ No

Details...

LIVING SKILLS

Please indicate applicant’s level of skill.

Personal Hygiene ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Cooking ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Cleaning ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Shopping ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Laundry ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Money Management ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Medication ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Transport ☐ Good ☐ Average ☐ Poor

Level of assistance required...

Does the applicant look after their own property? ☐Yes ☐No

Details...

Is the applicant respectful of other's property? ☐Yes ☐No

Details...

In your opinion what level of housing support does the applicant require? (Please give details)

High (Monday – Friday 8am – 6pm)..

Medium ....

Low (1 – 2 visits by staff per week)...

EDUCATION

Did the applicant attend high School? ☐Yes ☐No

If yes, at what level? ....

Does the applicant have any tertiary qualifications? ☐Yes ☐No

If yes, at what level? ....

Does the applicant have any trade qualifications? ☐Yes ☐No

If yes, please give details..

EMPLOYMENT

Please give the applicant's occupational history...

....

....

....

How long since the applicant was last employed? ☐Never ☐Past 12 months ☐ More than 12 months

Does the applicant have any hobbies or interests? ....

....

....

REHABILITATION

Has there been participation in past or is there any participation in present rehabilitation programs? ☐Yes ☐No

Please give details and contacts...

....

....

HOUSING

Has the applicant lodged an application with the Department of Housing? ☐Yes ☐No

Details...

....

Application Number: T...

Has the applicant had prior group living experiences? ☐Yes ☐No

Details...

....

Client's last known abodes?

Dates: .... to.......................... Place: ....

....

Dates: .... to.......................... Place: ....

....

Dates: .... to.......................... Place: ....

....

GENERAL

Does the applicant have any other community support systems? ☐Yes ☐No

Please give details (e.g. church, CALD community, club memberships): ....

....

....

What follow up procedures will be arranged by the referring agency? ....

....

Who will be responsible for this? ....

Is the applicant agreeable to such arrangements? ☐Yes ☐No

Has the applicant signed the ICLA Release of Information form? (Please see next page) ☐Yes ☐No

Are there any further comments that you would like to make about the applicant? ....

....

....

....

REFERRED BY

Name: ....

Signature: ....

Agency: ....

Date: ....

RELEASE OF INFORMATION FORM

I hereby authorise the Manager of Independent Community Living Association Inc. to request and receive written materials and other information relating to my medical/psychiatric/social history.

I understand that this information will only be obtained should I apply to reside at an ICLA residential facility. Further the manager will ensure that such material will be stored in a safe secure manner, with only authorised individuals having access to said records.

Applicant Name: ....

Signature: ....

Address: ....

....

Date: ....

Witness Name: ....

Signature: ....

Address: ....

....

Date: ....

CHECKLIST

Please ensure the following is included with this application:

Client has agreed and signed release of information form:

Support letter from treating Psychiatrist:	☐Yes	☐No
Occupational Therapist assessment (if applicant in hospital):	☐Yes	☐No
Discharge Summary upon discharge from hospital:	☐Yes	☐No
Other relevant support documents:	☐Yes	☐No
All questions have been answered on referral form:	☐Yes	☐No

The above information must be included before consideration for interview.

Please return applications to ICLA – details shown on page 1 of application.