

# Hills Community Support Group (Inc)



## Rainbow Program Referral Form

### ABOUT/FROM THE REFERRER – THE PROFESSIONAL

Name of Referrer: \_\_\_\_\_

Agency, address and contact details for Referrer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Referral: \_\_\_\_\_

Person being referred:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of birth: \_\_\_\_\_

Referrer's relationship to the person identified above: \_\_\_\_\_

Medical diagnosis for the applicant: \_\_\_\_\_

Current medication and treatment: \_\_\_\_\_  
\_\_\_\_\_

Other professionals currently working with the applicant:

Name: \_\_\_\_\_

Agency and contact phone number(s): \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Agency and contact phone numbers(s): \_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge does the applicant have:

private health insurance Yes / No

a criminal record Yes / No

a history of violence or aggression Yes / No

if yes, against whom and in what circumstances: \_\_\_\_\_

a history of drug and/or alcohol abuse/misuse Yes / No

a history of non-compliance with prescribed medication Yes / No

a violent or aggressive partner/family/dependents Yes / No

if yes, please detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ABOUT YOU – THE PERSON SEEKING SUPPORT TO LIVE IN THE COMMUNITY** (with the Rainbow Program, Hills Community Support Group)

Your name: \_\_\_\_\_

Where were you born? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

Your phone number: \_\_\_\_\_ (mobile): \_\_\_\_\_

Why did you want to be referred to the Rainbow Program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you identify with a particular cultural background? \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

Are you religious? \_\_\_\_\_

If yes, please explain in your own words: \_\_\_\_\_

\_\_\_\_\_

Do you prefer to speak a language other than English? \_\_\_\_\_

If yes, what language? \_\_\_\_\_

Do you have any interests or hobbies you'd like to tell us about? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Tell us about your education and any employment you have or have had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you receive a social security payment (eg from Centrelink, CSA, DVA, Affairs, etc)? \_\_\_\_\_

If so, which one: \_\_\_\_\_

\_\_\_\_\_

How do you get about? What transport do you use? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ABOUT YOUR FAMILY AND FRIENDS**

Are you married or partnered or living in a de facto relationship? \_\_\_\_\_

If yes, their details: \_\_\_\_\_

\_\_\_\_\_

Do you have any children? \_\_\_\_\_

If yes, please tell us about them (names, ages, where they live): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

Who would you like us to contact in case of emergency? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell us about any other family members or significant others in your life: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any pets? \_\_\_\_\_

**ABOUT YOUR HEALTH**

Tell us about your physical health (good, up and down, bad knees, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does it affect you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell us about your mental health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does it affect you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have problems with drug and/or alcohol abuse? \_\_\_\_\_  
Tell us what problems: \_\_\_\_\_  
\_\_\_\_\_

What medication are you taking and how do you get it? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who are your doctors?  
G.P. \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_  
Other: \_\_\_\_\_

Do you see any other health or helping professionals? \_\_\_\_\_  
If yes, please tell us their names and how to contact them:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have private health insurance? Yes / No  
Do you have private ambulance cover? Yes / No

**ABOUT YOUR BEHAVIOUR**

Are there any warning signs before an episode of your illness? \_\_\_\_\_  
Please tell us about them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there 'triggers' that can make you upset or angry or make your mental health worse? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you, or have you ever been, violent or aggressive to yourself or others? \_\_\_\_\_

What can make you this way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would we know if you are becoming unwell? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like to tell us anything else?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed (referrer): \_\_\_\_\_

Date: \_\_\_\_\_

Signed (applicant): \_\_\_\_\_

Date: \_\_\_\_\_

Please send to: Manager Rainbow Program HCSG Inc PO Box 123 Mundaring 6073 or fax to 9250 6437. Enquiries: 9250 5300

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## Authorisation to Share Information

I \_\_\_\_\_

give permission for a Rainbow Program staff member to share information about me with those people listed below

1. Swan/Coastal and Wheatbelt Adult Mental Health Service

2. GP \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

This authority expires six months after I leave the program.

Signed \_\_\_\_\_

Witness \_\_\_\_\_

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Date \_\_\_\_\_

### Informed Consent

***The Rainbow Program is unable to continue working with consumers who will not allow us to share information with their clinical service provider.*** If at any stage consent is withdrawn, we reserve the right to withdraw all services. This may include ending your tenancy. We will not share information for any reason other than through concern for your welfare, or that of your family (especially children) or our staff, or issues relating to your tenancy unless we are legally obliged to do so.

We will seek consent to exchange information with carers where appropriate and representatives of other organisations on a case by case basis with which you have an involvement. These may include schools, HACC service providers, healthcare professionals, rehabilitation service providers, religious organisations, legal services, and housing providers.