



Hills Community Support Group (Inc)

Rainbow Independent Living Program

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): _____

Name: _____

Agency and contact phone numbers: _____

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 to live in a Rainbow ILP house

Your name: _____

Where were you born? _____

Who do you live with? _____

Your phone number: _____(mobile): _____

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 (e.g. from Centrelink, CSA, DVA, etc)?

If so, which one: _____

How do you get about? What transport do you use? _____

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 ambulance cover? Yes / No

If so, please give details: _____

ABOUT YOUR BEHAVIOUR

Are there any signs before an episode of your illness? _____

Please tell us about them: _____

Are there 'triggers' that can upset or anger you or make you ill? _____

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

What can make you this way? _____

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 are they living?: _____

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

Do you have any pets? _____

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

ABOUT YOUR HOUSE

Where would you prefer to live (which suburbs?) _____

Why? (eg family support, schools etc) _____

What special needs do you have? (eg transport) _____

What help will you need to live independently? (eg learning to budget, clean, cook etc)

Have you lived independently in the past? _____ Yes/No

If so, how was it and how did it end? _____

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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.