

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

Hills Community Support Group (Inc)



Authorisation to Release / Exchange Information

I, _____ of _____
hereby authorise staff of Hills Community Support Group (Inc) Rainbow Program to release /
obtain / exchange information on my behalf from Departments / Agencies or Parties / Family
members listed below:

1. _____ Swan Adult Mental Health Service
2. _____ GP:
3. _____
4. _____
5. _____
6. _____

in relation to (specify nature of information): _____

I understand that the information concerns my personal affairs and may be considered confidential
and I give my permission for such information to be released / provided / exchanged by / to the
above named.

This authority expires upon my leaving the HCSG Rainbow Program.

Signed: _____

Witness: _____

Name of Witness: _____

Address: _____

Occupation: _____

Date: _____