Catherine House
Supported Accommodation Service Referral Form

Phone: 8232 2282 **Fax:** 8223 2313

Email: supportedaccommodationservice@catherinehouse.org.au

PLEASE NOTE, ONLY COMPLETE REFERRALS WILL BE CONSIDERED.

Additional Risk Factors:

☐ Pregnant > 27 weeks ☐ Rough sleeper ☐ Coordinated Care ☐ DV

Date of Referral: _____

PERSONAL DETAILS

Name: _____

DOB: _____ Age: _____

Gender: ☐ Female ☐ Other: _____

Contact number: _____ h2H Number: _____

By-Name List: ☐ Yes ☐ No VI-SPDAT Score: _____ Date completed: _____

Previous stay at Catherine House? ☐ Yes ☐ No SA Resident: ☐ Yes ☐ No

Referring agency: _____ Worker's name: _____

Phone number: _____ Alternative number: _____

Please nominate an additional worker who can discuss client if referrer unavailable:

Name: _____ Contact number: _____

Preferred Mode of Communication with Catherine House: ☐ Phone ☐ Email

Client Consent: ☐ Yes ☐ No

(Client verbally agrees for CH to share personal information with other services to assist with their support, ongoing case management and securing accommodation)

Aboriginal ☐ Yes ☐ No Torres Strait Islander: ☐ Yes ☐ No

Country of birth: _____ Residency status: _____ Year of arrival: _____

Cultural/Linguistic/Dietary needs: _____

Interpreter required? ☐ Yes ☐ No Dialect (if yes): _____

Emergency contact name: _____ Contact number: _____

Relationship: _____

Pregnancy:

Baby due date: _____ Doctor/Midwife assisting: _____

Risks associated with pregnancy: _____

_____

Hospital Booked: _____

Ambulance Cover: _____

HOUSING

Is client homeless tonight? ☐ Yes ☐ No

Reason for homelessness:

_____

_____

_____

Current address: _____

Last fixed address: _____

Type of tenure: ☐ SAHA ☐ Private rental ☐ Owned ☐ Other: _____

Date client left this address: _____

Reason for leaving:

_____

_____

_____

Restrictions to accommodation? ☐ Yes ☐ No Bail conditions / IO / Banned / Home detention

Children < 18: ☐ Yes ☐ No Where, will they reside: _____

CARL Report required: ☐ Yes ☐ No DCP Involvement: ☐ Yes ☐ No

Details: _____

_____

HEALTH

Significant health issues and disabilities (e.g. respiratory, diabetes, heart complaint, physical impairment, vulnerability, intellectual/physical disability, blindness, deafness):

_____

_____

COVID vaccinations:

How many: _____ Date of last vaccination: _____

Are there any issues which may impact on this client living in a communal setting? ☐ Yes ☐ No

If "Yes", please describe:

_____

_____

_____

Medications (Please name):

_____

_____

_____

Catherine House policy is that all medication is to be kept locked in an office and provided as prescribed. Catherine House staff require written instruction from a Medical Professional to alter any dosage.

Prescription needed? ☐ Yes ☐ No

Does the client use mobility aids? ☐ Yes ☐ No

If "yes", provide details:

_____

_____

_____

Able to climb stairs easily? ☐ Yes ☐ No

**Most Catherine House bedrooms are located up a flight of approximately 20 stairs.*

MENTAL HEALTH

☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Bi-polar ☐ Psychosis ☐ PTSD
☐ Borderline Personality Disorder ☐ Other: _____

Suicidal Ideation? ☐ Describe (level of risk, frequency of attempts, strategies in place):

_____

_____

_____

Self-harm? ☐ Describe:

_____

_____

_____

Risk to others? ☐ Describe:

_____

_____

_____

Hospital presentations (frequency, length of stay, treatment):

_____

_____

_____

Current support agency details (including frequency of appointments):

_____

_____

_____

Mental Health Care Plan in place? ☐ Yes ☐ No
Discharge summary/risk assessment ☐ Yes ☐ No
Safety plan ☐ Yes ☐ No

**All hospital referrals require up to date discharge summary/risk assessment. A safety plan may also be required if client is accepted for accommodation.*

ALCOHOL AND OTHER DRUG USE

Does the client have any issues with alcohol or other substances? ☐ Yes ☐ No

Details (Drugs, Alcohol):

_____

_____

Most recent use: _____

Amount used: _____ Frequency of use: _____

In the past 3 months, how often has this alcohol/drug use led to health, social, legal or financial problems?

_____

Has the client experienced withdrawal symptoms when stopping or cutting down AOD use?

☐ Yes ☐ No If "Yes", provide details: _____

_____

Is the client receiving treatment for AOD? ☐ Yes ☐ No

If "Yes", provide details (service, treatment, Pharmacotherapy): _____

_____

_____

NDIS

Does client have a current NDIS package? ☐ No ☐ Yes

If "Yes", provide details (what specifically does the package cover):

_____

_____

INCOME

☐ Job Seeker ☐ DSP ☐ Youth Allowance ☐ Parenting ☐ Wages ☐ No income

☐ Other: _____

☐ Income Management ☐ Public Trustee ☐ Basic Card

Date of last payment: _____ Date of next payment: _____

Able to pay rent at this time ☐ Yes ☐ No

If "No", reason for being unable to pay rent: _____

DOMESTIC/FAMILY VIOLENCE

Domestic violence (intimate partner) ☐ Yes ☐ No

Aboriginal family violence: ☐ Yes ☐ No

Risk of harm to client? ☐ Imminent ☐ Recent ☐ Within last 12 months ☐ Historical

Is client safe to remain where they are? ☐ Yes ☐ No

Safety Plan discussed with client? ☐ Yes ☐ No

Does client want to return to area of residence once safe to do so? ☐ Yes ☐ No

Medical treatment required? ☐ Yes ☐ No Medical clearance: ☐ Yes ☐ No

**Any individual who has experienced DV and has received injuries to their head/throat/abdomen will require a medical clearance before being accommodated.*

Police Report ☐ Yes ☐ No If "Yes", Report number: _____

DVRA Completed? ☐ Yes ☐ No If "Yes", completed by: _____

DVRA Score: _____ Please include DVRA report.

Linked with Family Safety Framework ☐ Yes ☐ No

Intervention Order: ☐ Yes ☐ No

Details of Alleged Perpetrator (if known): In custody? ☐ Yes ☐ No

If "Yes", provide details (including date of next court appearance): _____

_____

Perpetrator's Name: _____ DOB: _____

Gender: _____

Current location (if different): _____

_____

Please write details of the domestic violence

_____

_____

_____

_____

_____

_____

_____

_____

Catherine House is not a secure facility and is easily located and accessed. Please clearly detail any risk to staff and/or residents if the person is to be accommodated in our service:

_____

_____

_____

_____