NOUS

Supported Accommodation Services
Referral Form

ALL INFORMATION STRICTLY CONFIDENTIAL

Applicant

Preferred Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Surname:
Given Names:	Preferred Name/s:
Current Address:	
Usual Address (if different from above):	
Telephone:	Mobile:
Email:	Gender: ☐ Male ☐ Female
Date of Birth:	Country of Birth:
Preferred Language:	Interpreter Services Required: ☐ Yes ☐ No
Is the applicant:	☐ Aboriginal ☐ Torres Strait Islander

Next of Kin / Carer

Preferred Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Surname:
Given Names:	Preferred Name/s:
Current Address:	
Telephone:	Mobile:
Preferred Language:	Interpreter Services Required: ☐ Yes ☐ No

Referral

Agency Referred from:	
Referring Worker:	Position:
Phone:	Mobile:
Email:	
How long have you known the applicant:	
Preferred method of contact:	
Other Worker:	Position:
Phone:	Mobile:

Mental Health Information / History

What diagnosis does the Applicant have?	
Mental Illness Diagnosis	**Date of Diagnosis**
Other Medical Diagnosis/Conditions	

Are any of the following currently providing support or treatment to the Applicant?	
Support Service	**Name and contact details**
Community Mental Health	
Psychiatrist	
GP	
Clinical Psychologist	
Family	
Carer	
Other Support	

What medication is the Application currently on?	
Details:	
Is there a current Community Treatment Order?	☐ Yes ☐ No
Details:	
Is the Applicant already receiving any rehabilitation support?	☐ Yes ☐ No
If yes, where?	
*** Are there issues regarding use of illegal substances/alcohol?**	☐ Yes ☐ No
If yes, details of treatment:	
*** Is the Applicant at risk regarding self harm/suicide?**	☐ Yes ☐ No
Details:	
*** Are there any issues with challenging/violent/aggressive behaviours?**	☐ Yes ☐ No
Details:	
*** What strategies have been employed to deal with these issues?**	

Current Functioning and Living Skills

	Competent	Needs Support	Unskilled	No information
Personal care and Hygiene				
Interpersonal Relationships & Communication				
Money Management				
Time Management				
Public Transport				
Self Management of Medication				
Cooking				
Shopping				
Housework				
Laundry				
Comments:				

Accommodation / Housing Information

Why are the current / previous (if currently hospitalised) **living arrangements no longer appropriate?**

Has the Applicant lived on their own before?	☐ Yes ☐ No
Details – length/experience:	
Please comment on any housing issues/difficulties that may need extra attention and support:	

Has the Applicant lodged a housing application with Dept. Of Housing?	☐ Yes ☐ No
Housing T Number:	

Other supporting information / referees:

Consent

I (Applicants name): ______________________________

give my consent to the NOUS staff of the Schizophrenia Fellowship of NSW to receive the information contained in this application and to seek any further information from the Referrer concerning matters related to this application.

I confirm that I am interested in the NOUS Supported Accommodation Services and understand that this is a transitional program.

Signed: ______________________ Date: ______________________

The Privacy Act requires the Applicant, or person responsible, to sign this form giving their consent for the release of their information. The Referrer and Applicant agree that no information has been withheld and that all information provided is accurate and necessary for NOUS to provide a Duty of Care to the Applicant and meet its obligations to staff and volunteers.

Please email application to: nous@sfnsw.org.au