hope dignity awareness

huntington's victoria

Intake and Referral Form

Person Completing this Referral

DATE:

TYPE/SERVICE: ☐ Self ☐ Parent/carer ☐ Community Agency ☐ Hospital/medical

☐ HV internal referral ☐ Other (please identify)

NAME OF REFERRER: PHONE: EMAIL:

ADDRESS:

HOW DID YOU HEAR ABOUT OUR SERVICES?

DID THE CLIENT/REPRESENTATIVE CONSENT TO THIS REFERRAL? ☐ YES ☐ NO

Person Requiring Support

SURNAME: GIVEN NAME: TITLE:

DATE OF BIRTH: PHONE: EMAIL:

ADDRESS: POSTCODE:

SEX: ☐ Male ☐ Female ☐ Other MARITAL STATUS:

COUNTRY OF BIRTH: ABORIGINAL/TSI: ☐ Yes ☐ No

PREFERRED LANGUAGE: INTERPRETER REQUIRED: ☐ Yes ☐ No

ACCOM TYPE: ☐ Independent (community) ☐ Residential Aged Care (RAC) ☐ Homeless

☐ Shared Supported Accomodation (SSA) ☐ Supported Reisdential Service (SRS)

☐ Other (please identify)

LIVING SITUATION: ☐ Alone ☐ With family ☐ With others (please identify)

NOK/Carer

NAME: ROLE:

ADDRESS:

PHONE: EMAIL:

16 Wakefield Street, Hawthorn VIC 3122 www.huntingtonsvic.org.au

P 03 9818 6333 F 03 9818 7333 E info@huntingtonsvic.org.au

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Guardian/Administrator/EPOA

NAME: ROLE:

ADDRESS:

PHONE: EMAIL:

Medical Details and Current Health Status

HD STATUS: At Risk Gene negative Gene positive Symptomatic/diagnosed

Carer

OTHER DIAGNOSIS/MEDICAL CONERNS:

NAME AND ADDRESS OF SPECIALIST:

CONTACT DETAILS:

NAME AND ADDRESS OF GP:

CONTACT DETAILS:

WHEN WAS THE CLIENT LAST SEEN BY A SPECIALIST? If they have not seen their specialist for over 6 months, please indicate what has prevented this from occuring.

Behaviour

Please indicate whether or not the following behaviours are present. Where behaviours have been indicated as present, please provide examples. Please note that a lack of detail may result in some delay in processing this referral.

Behaviour	Present		Examples
Verbal Aggression	Yes	No	
Physical Aggression	Yes	No	
Socially inappropriate behaviour	Yes	No	
Perseveration (repetitive behaviours)	Yes	No	
Apathy/poor initiation	Yes	No	
Sexually inappropriate behaviour	Yes	No	
Impulsivity	Yes	No	

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Physical Presentation

Please indicate whether or not the following are present. Please provide examples when appropriate. Please note that a lack of detail may result in some delay in processing this referral.

Indepedent with personal care	Yes ☐	No ☐	If no, please elaborate:	
Swallowing difficulties	Yes ☐	No ☐	Meal type:	
Indepedent with meal preparation	Yes ☐	No ☐		
Falls risk	Yes ☐	No ☐	If yes, please indicate frequency:	
Driving	Yes ☐	No ☐		
Mobility aids	Yes ☐	No ☐	Please indicate (e.g. wheelchair):	
Communication	Yes ☐	No ☐		

Cognition/Emotion

Please indicate whether or not the following are present. Please provide examples when appropriate. Please note that a lack of detail may result in some delay in processing this referral.

Able to make own decisions	Yes ☐	No ☐	
Can initiate activties	Yes ☐	No ☐	
Can manage own finances	Yes ☐	No ☐	
Requires routine	Yes ☐	No ☐	
Depression/anxiety	Yes ☐	No ☐	
Has frequent outbursts	Yes ☐	No ☐	

Reason for Referral

Please outline what supports/services are being requested from Huntington's Victoria.

Clear identification of issues. Please outline each individual issue or area of concern. (e.g. personal care, community access, relationship breakdown)

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Clear identification of current needs. These should relate to the issues identified above (e.g assistance with showering, dressing, etc).

Please identify services currently involved and current referrals (e.g. HACC, linkages, allied health).

Risks. What are the current risks if any to the client at present? What supports have been identified/implemented/referred to help minimize current risk? (e.g. client at risk of falls, failure to attend to personal care needs & premature)

Please Indicate any recent specialist assessments & outcomes

Please attach all relevant supporting documentation (referrals cannot be processed until sufficient documentation is received).

Neuropsychological	Attached ☐	To follow ☐	Not Available ☐
Medical/psychiatric	Attached ☐	To follow ☐	Not Available ☐
Physiotherapist	Attached ☐	To follow ☐	Not Available ☐
Speeth pathologist	Attached ☐	To follow ☐	Not Available ☐
Occupational therapist	Attached ☐	To follow ☐	Not Available ☐
Other, please specify:	Attached ☐	To follow ☐	Not Available ☐

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Client Consent

Please note that this referral will not be processed without the client's consent.

- By signing this form, potential client and/or their representative acknowledges:
- Consent to becoming a client of Huntington's Victoria and permission to creation of client file
- Receipt of information about client rights and responsibilities, confidentiality of information and feedback process
- Understanding that Huntington's Victoria may use and disclose any information obtained to other persons and agencies for the purposes of providing services in relation to client's current care plan This may include but is not limited to:
    - Huntington's Victoria Staff Members
    - Department of Health and Human Services
    - National Disability Insurance Agency
    - Other relevant health and community service providers

Written Consent		**Verbal Consent**	
Signature:		Signature:	
Name:		Name:	
Relationship to person:		Relationship to person:	
Date:		Date:	

SENDING THIS REFERRAL

Please ensure you have completed all relevant information before sending. If filling out online, click the **Submit Form** button below. If filling out by hand, please scan and send to **intake@huntingtonsvic.org.au** or fax to **03 9818 7333.**

Ph: 03 9818 6333
Website: www.huntingtonsvic.org.au

SUBMIT FORM