Huntington's Victoria Service Referral Form

Please complete this form ONLY if a clear need for referral to one of the HV services has been identified.

Person Completing this referral:			
Date of referral	**Name of the referrer**	**Phone number**	
Name of the agency (if applicable)		**e-mail**	
Relationship to the person requiring support	☐ Self ☐ Parent/Carer	☐ Community Agency ☐ Hospital/Medical	☐ Other (pls. identify) _____
Where did you hear about HV?	☐ HV website	☐ Family ☐ Hospital/Medical	☐ Other _____

Person Requiring Support:			
Name	**Surname**	**Gender** ☐ Male ☐ Female ☐ Other	
DOB	**Contact details (phone/e-mail)**		
Address		**Postcode**	
Interpreter required?	☐ No ☐ Yes	If yes, what language? _____	
Can this person be contacted directly?	☐ Yes ☐ No	If not, why? _____	

Eligibility:

Person requiring support (please tick one)

- ☐ **Has a diagnosis of Huntington's Disease**
- ☐ **Has a family history of Huntington's Disease**
- ☐ **Is eligible for services through the Department of Health and Human Services (DHHS) or the National Disability Insurance Agency (NDIA) in accordance with the Disability Act 2006 and NDIS Act 2013**

Primary Diagnosis: _____

Secondary/emergency contact:			
Name		**Contact details (phone/e-mail)**	
Relationship to the person requiring support	☐ NOK ☐ Guardian	☐ EPOA ☐ Friend	☐ Other (pls. identify) _____

Reason/-s for referral:

You must clearly identify goals and service needs for this referral to be considered

Please outline each individual issue or area of concern (i.e. personal care, community access, accommodation, relationship breakdown)

PTO

Current supports and services pertinent to this referral:		
Please identify all informal/formal supports currently available: (e.g. family, HACC, linkages, allied health, DHHS)		
Type of Support	**Who provides these supports**	**Contact details**
GP's name	**Contact details**	
Address		

Consent:		
I, _____(the person or the representative of the person requiring service) am fully aware that by signing the Huntington's Victoria Service Referral Form Consent:		
☐ I agree to this referral ☐ I give permission for HV to create a record under my name and I understand that any information collected by HV about me is treated confidentially ☐ I give permission to HV to obtain information from people and services listed above and share relevant information with other service providers in relation to this referral ☐ I understand that I can withdraw from HV services at any time ☐ I acknowledge that the Huntington's Victoria Client Rights and Responsibilities have been explained to me and I understood these Rights and Responsibilities		
I have identified the following restrictions to the scope of this consent: _____		
Name		**Signature**
Date	**Relationship to the person requiring support (if applicable)**	

Submitting the referral:

Please make sure that consent has been completed and signed by the service user (or representative) prior to submitting this referral. Please note that referrals without signed consent will not be processed.

Please ensure you have attached all relevant information (i.e. recent specialist and/or allied health assessments) to support the referral.

Completed referral forms can be sent to:
Email: intake@huntingtonsvic.org.au
Fax: 03 9818 7333 (Attention: Intake Officer) or
Mail: PO Box 2112, Hawthorn Vic 3122 (Attention: Intake Officer)

Huntington's Victoria ensures that all valid referrals are treated fairly and equitably. All referrals are subjected to an assessment process and endorsed by an internal panel.