

ASSESSMENT TOOL – PART A

Referral & Intake

This tool can be utilised by the following programs: ISI, HHS, Care Finder, CHSP and NDIS. Refer to the specific program guidance document for support to complete what is required. Self-referrers may also use this tool.

External Agencies – to complete when referring a client to Wintringham's HHS and Care Finder services. Housing Access Points can submit IAP referral form with Part A. All other agencies will also complete Part B. Asset limits will apply. Speak to our Intake and Service Information (ISI) team for further information. * Replicate IAP fields ** Applicable to internal programs only. **Client consent required on page 5 to proceed with referral.**

Referral Information

* First Name: _____	* Surname: _____
* DOB: _____	** Client under 65? Consider NDIS referral
What service are you requesting? <input type="checkbox"/> Housing	<input type="checkbox"/> NDIS <input type="checkbox"/> Care Finder
<input type="checkbox"/> Privately funded services <input type="checkbox"/> Outreach Support	<input type="checkbox"/> CHSP <input type="checkbox"/> RAC
* Source of referral (agency): _____	
How did they get in contact: _____	
* Worker's Name: _____	* Date: _____
* Email: _____	* Phone: _____
* Reason for referral / current situation?	
What support do you need?	

Client Details

* Preferred Name: _____	Pronouns: _____
* Address (current/postal): _____	
* Phone: _____	* Mobile: _____
How should we communicate with you when scheduling appointments?	
<input type="checkbox"/> Phone call <input type="checkbox"/> SMS <input type="checkbox"/> Other (specify): _____	
* Is it safe call or text this number and leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is it safe to send mail to the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No Email? _____	

Client ID

* Income type: _____	Centrelink number: _____
Card number: _____	Medicare number: _____
Expiry date: _____	Medicare expiry date: _____
Aged Care number: _____	NDIS Number: _____
Referral code for service (My Aged Care) _____	Plan Date – Start: _____
	Plan Date – End: _____

Client Information

* Gender identity: _____	* Interpreter required: _____
* LGBTIQ+: _____	* If Yes, language: _____
* Indigenous status: _____	Cultural background: _____
* Veteran: _____	Religion / belief: _____
* Forgotten Australian: _____	Citizenship: _____
* Country of birth: _____	Asylum seeker: _____
Preferred language: _____	Visa conditions: _____
Arrival Date: _____	
Carer involvement? Details listed on Supports page	

Client's (Preferred) Name: _____

Risk Assessment

<p>* Any behaviours of concern we should be aware of? <i>e.g., Aggression – to or from others History of violence Alcohol and Other Drug issues Mental health considerations</i></p> <p>** Has a Behaviour and Risk Management Plan been completed?</p>	
<p>Any triggers we should be aware of? <i>(i.e. environment, people, past experience)</i></p>	
<p>* Any disability considerations? <i>e.g. communication needs (i.e., literacy - reading, writing), mobility</i></p>	
<p>Information important for first meeting? <i>e.g. pronouns, ATSI, safety</i></p>	
<p>Do you need anyone else with you at the assessment? <i>e.g. worker, NOK, family, guardian / advocate</i></p>	

Other Information

<p>Health Information? <i>i.e. frailty, mobility, mental health, cope in heat</i></p>	
<p>Do you have any other unmet support needs? <i>i.e. Medical, aging, legal, court, current orders, hoarding, finance etc.</i></p>	

Client's (Preferred) Name: _____

Any other information?	
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Housing

Experiencing homelessness?	
Are you able to live independently?	
* Current housing situation:	
How long can you stay there?	
* Who do you live with? <i>Household details i.e. family/friends, pets etc.</i>	
* Housing need: <i>i.e. type of housing is required</i>	
* VHR Application <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, VHR Number:
If interested in Wintringham Housing, list site preferences? <i>Sites listed on Wintringham website.</i>	
* Housing History: <i>Last 6-12 months</i>	

Family Violence Screening

Do you currently feel unsafe or afraid of anyone? If yes, can you tell me why?	
Do you need any immediate assistance to make you feel safe?	
Do you have any current/pending family violence orders in place that we should know about? <i>i.e. Personal Safety Order / Family Violence Intervention Order Victim survivor or perpetrator?</i> Court Dates?	

Client's (Preferred) Name: _____

Safety plan in place?	
<i>If you are concerned about the immediate safety of your client – escalate to your supervisor, call for Victoria Safe Steps on 1800 015 188 or Tasmania Safe at Home Family Violence Referral 1800 633 937 or police if necessary.</i>	
<i>** If yes, please contact your Coordinator to discuss next steps (i.e. MARAM Risk Assessment)</i>	

Supports

Emergency Contact

First Name: _____	Surname: _____
Phone: _____	Mobile: _____
Email: _____	
Relationship to client: _____	
Permission to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>** If Yes, consider whether NOK Nomination from required</i>	
Under what circumstances? _____	

Carer

Name: _____	Phone: _____
Type and frequency of support: (living arrangement, how often do they attend, what type of support do they provide?)	
Is the carer experiencing stress associated with their caring role? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Wintringham

Are you a current Wintringham client? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, which site/program? _____

Other Supports

GP, psychologist, counsellor, legal representation, disability worker, financial administrator, guardian, mental health outreach worker, Aged Care (CHSP/HCP), Disability (NDIS), CISP, corrections, advocate, child protection, family violence services, family, friends or significant others.

* Support Provided	Service Name	Worker Name	Contact details

Client Consent

Client's (Preferred) Name: _____

Written consumer consent (Please tick if this option is selected)		<input type="checkbox"/>
<i>This referral has discussed with me and I give my consent for the information to be shared with Wintringham, for the purposes of the referral.</i>		
Client signature		
Print name		
Date of signature		

OR

Verbal consumer consent (agency use only) (Please tick if this option is selected)	<input type="checkbox"/>
<i>I have discussed and informed the client about the information in this document being shared with Wintringham, as part of the referral process. I am satisfied that this has been understood by the client and that informed consent has been provided for the information to be shared.</i>	

Internal Use Only

Referral accepted
<input type="checkbox"/> Yes Initial Visit – Pre-Screening Tool to be completed when proceeding with referral <input type="checkbox"/> No please explain why and action taken/by who _____

Paperwork / Follow up tasks required (tick what's required)
<input type="checkbox"/> Consent to Obtain and Exchange Information Form <input type="checkbox"/> Authorisation for Centrelink (Income and Asset Consent) <input type="checkbox"/> Download information from VHR <input type="checkbox"/> Add risk alert on SHIP / GoldCare noticeboard <input type="checkbox"/> Obtain NDIS Plan/ Request for Service (with consent) <input type="checkbox"/> Put in Referral Code / Obtain NSAF from My Aged Care

Nomination for Housing
<i>Please send the below documents, including a copy of this Ax to the housing site you are nominating your client for.</i>
<input type="checkbox"/> Copy of Ax. Tool (Part A) and (Part B if applicable) <input type="checkbox"/> Copy of Centrelink Income and Assets Statement <input type="checkbox"/> Copy of confirmation of priority access on the VHR <input type="checkbox"/> Pet Owner? (Complete the Pet Assessment & Agreement Form) <input type="checkbox"/> Details of support worker nominating. Name: _____ Contact Number: _____

