Corandirk House - Supported Residential Service

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Consent to Release Information: (Nominated Health Professional to complete this section). All information will be treated in a professional and confidential manner.

I,_________________________________ (Applicants name) give my consent to the Proprietors of Corandirk House , the Support Services and orth West Area Mental Health Service (NWMAHS) to seek information concerning Nmatters related to this application from my nominated health professional. I am aware of this application and consent to its release to the above named programs.

Name of Nominated Health Care Professional:______________________________

__________________________________ ______________

(Signature of Applying Client) (Date)

Client Details:

First Name: _____________________ Family Name: ____________________

Also Known As:____________________ D.O.B. _____/_____/_______

Address: _____________________ Male / Female (please circle one)

____

_____________________ Postcode:_________ Contact Number: ______________

Spouse/Partner: ___________________ Children: ________________________________

Religion? _______________________ Cultural Background: _________________________

Interpreter Required? **For Client** Y / N **For Carer** Y / N Preferred Language: _______________

Medicare No:_______________________ Expiry Date:_____________

Pension No: _______________________

Contact Person (NOK, Carer): ____

Address: ____

Phone No:____________________________

Case Management Details:

Treating Psychiatrist: ___________________ Contact Number: ____________________

Case Manager: ______________________ Contact Number: ____________________

How long have you been case managing client? ______________________________

Frequency of Contact (phone/in person): _____________________________________

Frequency of Contact: __________________

Treatment and Clinical Summary:

Community Treatment Order: Yes / No Date Commence: ____/____/______

Next Review Date: ____/____/______ Treating Psychiatrist: ________________________________

Guardianship Order: Yes / No Name of Guardian: ________________________________

Administration Order: Yes / No Name of Administrator: ________________________________

Administrator Reference Number: ______________________

Clinical Summary – Please attach most recent Discharge Summary if available

Primary Diagnosis: ____

Secondary Diagnosis: ____

Past History: ____

____

____

____

____

____

Clients Understanding of and attitude to their illness: ________________________________

____

Clients Attitude to Medication: ____

____

Current Medication	Dose	Frequency	Side Effects

Physical Health:

Medical History: ____

____

____

Current General Health and Management:____

____

Current GP: ______________________________ Address: ______________________________

____

Telephone: ______________________________ ______________________________

Personal Safety and Safety of Others:

Suicide attempts/self harm behaviour: ___

___

___

Aggressive behaviours/harm to others: ___

___

Substance Use: ___

___

Forensic History: (give details)___

___

Risk to others through self-neglect of vulnerability: ___

___

Cardinal Signs of Relapse: ___

___

Individual Service Plan / Current Management:

Does client have a current Individual Service Plan (ISP)?: (if yes please supply copy)

Yes / No
(Please circle)

Outline current management plan, as per ISP: ___

___

___

___

Family: (Please indicate all relevant information regarding dependant children, family, carers, or other culturally significant considerations).

Genogram:

Background and current situation: ___

___

Families understanding of and attitude towards illness: ___

___

Prior Housing History:

___

___

Relevant accommodation issues: ___

___

Finances:

Source of Income: ___

Money Management Skills: ___

Relevant Financial Issues: ___

Daily Living Skills:

Please comment on Daily Living Skills (What are the clients support needs):

___

___

Strategies for dealing with stress (useful and problematic): ___

___

Education and work (past and present): ___

___

Leisure and Interests (past and present): ___

___

Other Information:

Involvement with Community Agencies: ___

___

Personal Strengths: ___

___

Other Information: ___

___

Important Information for referring Health Care Professional

If the referring service anticipates that the client will require mental health services, ie. Case Management a separate formal referral must be made to the appropriate North West Area Mental Health Services, eg. MST, CCT. *Written referrals to be sent to: 130 Bell St, Coburg.*

Clinical responsibility remains with the referring agency until assessments for case management are completed. Please allow 6 weeks for completion of assessments.

___(Printed name of Referring Health Care Professional)

___ (Signature)

___/___/___ (Date)