Day to Day Living (D2DL)
Housing and Support Initiative (HASI)
Personal Helpers and Mentors (PHaM)
Resources and Recovery Services Program (RSSP)

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Please attach a completed Review form, and complete and attach a Mental Health Assessment, Risk Assessment, Home Visit Risk Assessment, Discharge Summary (if appropriate)
Please direct all referrals to the RehabilitationTeam Leader at 9794 1986

DATE OF REFERRAL __________________

Referring Service_________________________Phone______________Fax____________________

Primary clinician__________________________Mobile______________Designation_____________

Psychiatrist______________________________Phone______________Mobile__________________

General Practitioner_______________________Phone______________Fax_____________________

CONSUMER DETAILS

Surname__________________________________Other names______________________________

Address____

Phone______________________ Date of Birth ____________________MRN___________________

Present location of consumer____

REASON FOR REFERRAL

Is the client aware of the referral? ☐ Yes ☐ No Does the client agree with the referral? ☐ Yes ☐ No

Specific reason for the referral: ____

____

Which program are you referring the consumer to?

D2DL ELIGIBILITY CRITERIA – does the consumer

Have a mental health diagnosis for which they are currently receiving treatment? ☐ Yes ☐ No
Aged over 18 years? ☐ Yes ☐ No
Have a primary contact person for their health needs? ☐ Yes ☐ No

HASI ELIGIBILITY CRITERIA – does the consumer

Have a mental health diagnosis and association functional disability? ☐ Yes ☐ No
Fall within ages 16-65 years? ☐ Yes ☐ No
Have housing and support needs? ☐ Yes ☐ No
Require current acute care inpatient treatment? ☐ Yes ☐ No
Indicate a willingness to participate? ☐ Yes ☐ No
Have the skills to manage independently for periods, particularly overnight? ☐ Yes ☐ No
Please complete Appendix 1

The Housing and Support Initiative (HASI) – Description of HASI support options

Name of HASI package	Support hours per week	Referral must have:	Tick Level of support required	Complete Appendix 1
Low Support	Up to 5 hours	Existing DOH or community housing tenancy that is considered at risk and low support needs		
High Support	Up to 25 hours	No accommodation options and high support needs		√
High High Support	Up to 38 hours	No accommodation options and requiring very high support		√

PHaM ELIGIBILITY CRITERIA – does the consumer

Aged over 16 years? ☐ Yes ☐ No
Are willing and able to agree to participate? ☐ Yes ☐ No
Have a severe functional limitation as a result of severe mental illness? ☐ Yes ☐ No
Live in the community? ☐ Yes ☐ No
Are willing to address drug and alcohol issues? ☐ Yes ☐ No

RRSP ELIGIBILITY CRITERIA – does the consumer

Have a mental health diagnosis and associated functional disability? ☐ Yes ☐ No
Fall within ages 16 – 65 years? ☐ Yes ☐ No
Have educational, vocational, recreational or leisure support needs? ☐ Yes ☐ No
Require current acute care inpatient treatment? ☐ Yes ☐ No

The Day to Day Living Program (D2DL)
A primarily centre based service, targeting people interested in increasing their participation in social, recreational, vocational and educational activities.

The Personal Helpers and Mentors program (PHaM)
PHaM aims to enable people to develop capacity to manage their daily lives and move towards active participation by providing support around areas such as household management, self care, transport, finances and medication; and advocacy in accessing a range of community resources. This is done through direct service provision and referral to relevant services.

Resources and Recovery Services Program (RRSP)
Consumers are offered low level support to access recreational and or vocational support. Support may range from phone contact up to a couple of hours face to face support per week.

Client Consent Form

1. Client consent

I , ……………………………………………agree to my personal information being collected, held and sent to the following agencies:

- The Day to Day Living (D2DL) Program
- The Housing and Support Initiative (HASI)
- The Personal Helpers and Mentors (PHaM) Program
- The Resources and Recovery Services Program (RRSP)

so that they can assess my request for services. I understand you may collect my information for statistical purposes, but that it will not identify me personally in any way.

I also understand that my consent means details of my ethnic or racial origin, and religious belief, may be provided to the agencies listed above so that they may be able to provide me with a culturally appropriate service.

I understand I can retract my consent at any time. I am giving my information voluntarily.

Signed:……………………………………………. Date: …/…./….

2. **Verbal consent by consumer** (to be used only if it is not practical to get written consent of client)

I, …………………………………………………. Of Fairfield and Liverpool Mental Health Services, SSWAMHS, on (date) …/…/… obtained the verbal informed consent of …………………………………………….. (print client's name) giving permission for this agency to collect, hold and send their personal information to the agencies listed above to be assessed for services.

APPENDIX 1 (for HASI Referrals only)

Inpatient Care within the last 12 months (from the most recent):
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____

☐ >300 days ☐ 150 – 300 days ☐ 90 – 150 days ☐ < 90 days

Comments: ____

____

Previous Hospital admissions (from the most recent):
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____
Hospital:______________________ Admission:____/___/___ Discharge:____/___/___ No. days:____

CURRENT HOUSING

- ☐ Housing NSW T Number: ________________________ Active ☐ Yes ☐ No
- ☐ Community Housing
- ☐ Private Rental
- ☐ Family / friends
- ☐ Acute / non acute psychiatric unit
- ☐ Homeless
- ☐ Other: ____
- ☐ Resident of area ☐ Previous resident of area ☐ New to the area

Describe the current housing situation:

____

____

____

Why does this need to change? (if applicable)

____

____

____

Is the current tenancy at a potential / real risk? ☐ Yes ☐ No

Reason: ____

____

____

Have there been previous tenancy issues? ☐ Yes ☐ No

Details: ____

____

____