# HARP SFT Referral Information Guide

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| **Identify** | **Patient Name** | |
| | **UR Number** | |
| | **Address** | |
| | **Contact Number** | |
| **Situation** | **Admission details**<br><br>**Number of previous admissions / presentations** | *Please attach supporting documents (eg Discharge summary, f/u appointments, GP and Next of kin details)* |
| **Assessment and Background** | **Community Services History** | • Is the client currently receiving any community services? ☐ Yes ☐ No ☐ Unknown<br>*If yes – please provide details:*<br><br>• Have any other new referrals been made for this client (e.g. PAC or MAC)? ☐ Yes ☐ No<br>*If yes – please provide details:*<br><br>• ***MAC Reference No: (if applicable)*** **_____**<br>• Does the client have a history of poor engagement with services? ☐ Yes ☐ No ☐ Unknown<br>*If yes, Please list known barriers to service engagement:* |
| | **GP Engagement** | • Does the client have a regular GP for medical follow up? ☐ Yes ☐ No ☐ Unknown<br>• Last GP appointment (if known):<br>*(Please confirm GP details)* |
| | **Housing** | • Is the client homeless or at risk of homelessness? ☐ Yes ☐ No *(If yes – consider referral to Homeless Persons Program and/or housing services)*<br><br>• Have any concerns regarding the client's home environment been raised? (e.g. access issues, reports of hoarding or unsanitary conditions) ☐ Yes ☐ No<br>*If yes, please give details:* |
| | **Mental Health** | • Is there a documented history of mental illness? ☐ Yes ☐ No<br>*If yes, please give details:*<br><br>• Has the client been previously engaged with mental health services? ☐ Yes ☐ No ☐ Unknown<br>**If yes**: Is the client currently engaged? ☐ Yes ☐ No<br>When was client last engaged?<br>Organisation?<br>*(Please consider a referral to Mental Health Services as required*) |
| | **Alcohol and Drugs** | • Does the client have current issues with alcohol or Drug abuse? ☐ Yes ☐ No ☐ Unknown<br>**If yes:**<br>• Is there evidence that this impacts on the client's behaviour or function? ☐ Yes ☐ No ☐ Unknown<br>*If yes, please give details:*<br><br>• Is there evidence that this impacts on others around the client? ☐ Yes ☐ No ☐ Unknown<br>*If yes, please give details:*<br><br>• Has a referral to Drug and Alcohol Services been discussed with the client? ☐ Yes ☐ No<br>*If yes, please give details, including client's response:*<br><br>• Is there evidence of Alcohol or drug use by other people living with client? ☐ Yes ☐ No ☐ Unknown<br>*If yes, please give details:*<br><br>*(Please consider a referral to Drug and Alcohol Services or Addiction Medicine as required*) |

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| | **Cognition** | • Does the client have impaired cognition? ☐ Yes ☐ No ☐ Unknown<br>**If yes:**<br>• Is there evidence that impaired cognition impacts the client's safety and function? ☐ Yes ☐ No<br>*If yes, please give details:*<br>• Has an MMSE/RUDAS been completed recently? ☐ Yes ☐ No *If yes, please attach*<br>• Has the client's capacity to make decisions been formally assessed? ☐ Yes ☐ No ☐ Unknown<br>*If yes, please give details/attach relevant reports*<br>• Is the client able to make decisions to accept/decline services? ☐ Yes ☐ No ☐ Unknown<br>• Has the client appointed a substitute decision maker? ☐ Yes ☐ No ☐ Unknown<br>*If yes, please give details:*<br>• Has formal documentation (eg EPOA) been sighted? ☐ Yes ☐ No<br>*(Please consider a referral to CDAMS as required*) |
| | **Behaviour** | • Is there evidence that the client has been physically or verbally aggressive in recent times? ☐ Yes ☐ No<br>**If yes,** please give details (including known triggers or causes behind the behaviour and management strategies employed by hospital staff)<br>• Are you aware of any other potential risks to staff or client safety if visiting this client in the community? (Please consider Intervention orders, domestic and elder abuse, neglect, etc.) ☐ Yes ☐ No<br>*If yes, please give details:* |
| **Requirement** | **Informed Consent** | *Has someone explained the HARP Service to the client (or representative)?* ☐ *Yes* ☐ *No*<br>*Has the client consented to this referral* ☐ Yes ☐ No |
| | **Reason for referral** | *(Including what the client sees as their primary goal, what the desired outcomes of the referral are, any further information that will assist the team address this clients needs)* |

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| **Date of Referral** | |
| **Referrers Name** | |
| **Referrers Designation** | |
| **Referrers Contact Details** | |