

# BROWN NURSES CLIENT REFERRAL FORM

## Client information

First name:

Last name:

Address:

Suburb:

Postcode:

Gender identification:

Religion:

Home phone:

Mobile phone:

Date of birth:

Place of birth:

Mother's maiden name:

Father's name:

Next of kin:

Next of kin address:

Suburb:

Postcode:

Next of kin phone:

Interaction with their family:      Frequent              Infrequent              None

Interaction with their friends:      Frequent              Infrequent              None

Relationship to referrer:      Spouse              Partner              Parent              Other  
   Sibling              Other relative              Friend

***All fields mandatory.***

***Please add extra pages if information does not fit on this form.***

***Please save completed form on your computer before sending.***

## Referee information

Referred by: Agency Self Family Friend

Agency name:

Agency type: Hospital Community Health / Mental Health  
Drug & Alcohol Service Homeless Service  
Government Agency NGO  
Other

Referrer's name:

Referrer's position:

Referrer's phone:

Referrer's mobile:

Referrer's fax:

Referrer's email:

## Reason for referral

Medication management

Advocacy/liaison with other agencies

Personal care

One-off assistance

General support/monitoring

Other (please provide details)

Domestic assistance

Has the client been referred to other services?

Are other services already involved in client care?

***All fields mandatory.***

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## Medical history

GP name:

Contact details:

Medical specialist name:

Contact details:

Medical conditions / current health status:

Current medications / compliance:

## Mental health history

Psychiatrist name:

Contact details:

Case manager name:

Contact details:

Emergency contact number (e.g. Acute Care Team):

Mental health diagnosis / current status:

Current mental health medications / compliance:

Signs and symptoms of mental health deterioration:

Is the client under a Community Treatment Order:

No

Yes

Expiry date:

***All fields mandatory.***

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## Known risks

Infection:	No	Yes
Violence:	No	Yes
Forensic:	No	Yes
Substance abuse:	No	Yes
Other (please provide details)		

## Other information

Guardianship:	No	Yes	
Guardianship type:	Public	Other	
Financial management:	Self	NSW Trustee	Other (please provide details)

Pension type:	Disability Support Pension	Aged Pension
	Sickness Benefit	Newstart
	Open Employment	Other (please provide details)

Pension No: Pension expiry:

Medicare No: Medicare expiry:

***All fields mandatory.***

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Housing:                      Own house/unit                      Public housing  
   Private rental                      Boarding house  
   Supported accommodation program                      Hostel / short-term accommodation  
   Homeless                      Other (please provide details)

Has the Client lodged an application with Housing NSW:                      No                      Yes (please provide details)

Application No:

Client's last known address:

## DISCLAIMER

I / We acknowledge that this referral was discussed with the Brown Nurses prior to lodgement.

I / We understand that acceptance and commencement of service is not automatic, but dependent on the Brown Nurses' service capacity at the time of referral and satisfactory risk assessments.

**Please email your completed referral to  
brownnurses@brownnurses.org.au or fax to 02 9518 9644**

***All fields mandatory.***

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***Please save completed form on your computer before sending.***