High Needs Panel Referral Form

Please return to: highneedspackage@homelessnessnsw.org.au

Section 1	Name and contact details of person making referral
Name	
Job title	
Organisation	
District	Choose an Item
Email	

Telephone		**Date Referred**	

If there is anyone else that might be better placed to provide any additional information that needed to support the referral, please provide their details, and inform them that someone from the High Needs Panel may be in touch if more information is required.

Name:	
Organisation	
Telephone	
Email	

Engagement with frontline services

Select **ONE** statement that best applies to the individual being referred:

In the last month they:

- ☐ Rarely missed an appointment.
- ☐ Usually kept appointments and routine activities; followed through with reasonable requests, engaged in accessing other services.
- ☐ Followed through some of the time with daily routines or other activities; sometimes followed through with reasonable requests; minimally involvement with other services.
- ☐ Were irregular with routine activities or rarely engaged with reasonable requests, though kept some appointments.
- ☐ Did not engage at all or keep appointments

Section 2	Individual details

Name		**D.O.B**	

Current VI-SPDAT Score		**Previous VI-SPDAT score**	

Individual identifies as Aboriginal and/or/both Torres Strait Islander	**Yes** ☐ **No** ☐
Individual identifies as Aboriginal and/or/both Torres Strait Islander and over 45 yrs.	**Yes** ☐ **No** ☐
Individual identifies as LGBTQI+A	**Yes** ☐ **No** ☐
Female	**Yes** ☐ **No** ☐
Individual under 24 yrs.	**Yes** ☐ **No** ☐
Individual over 55 yrs.	**Yes** ☐ **No** ☐

Current living situation

Rough Sleeping	**Yes** ☐ **No** ☐
Temporary Accommodation	**Yes** ☐ **No** ☐
Transitional Housing	**Yes** ☐ **No** ☐
Housed	**Yes** ☐ **No** ☐
Living in overcrowded housing	**Yes** ☐ **No** ☐
Other (please provide details)	

Section 3 Reason for referral

Length of time cycling between homelessness and temporary accommodation	☐ weeks ☐ months ☐ years
VI-SPDAT score is less than 15 but individual has chronic at-risk health conditions that requires urgent review. If answer is 'No' please discontinue referral	**Yes** ☐ **No** ☐

Mental Wellbeing	
Physical Health	
Substance Use	
Current risk to tenancy	

Other	

Section 4	Summary of risks		
	Current (last 2 weeks)	Recent Past (last 6 months)	Historical Past (over 6 months)
Self-Harm	☐	☐	☐
Harm to others	☐	☐	☐
Suicidal thoughts/intentions	☐	☐	☐
Physical/sexual/emotional abuse	☐	☐	☐
Significant medical needs/Disability	☐	☐	☐
Alcohol/Drug use	☐	☐	☐

Section 5	Referral History
NDIS ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
Mental Health ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
HASI ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
GP ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
Drug & Alcohol Service ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
Other ☐ Current ☐ Previous referral	Provide details to any barriers encountered when making referral to this service
Please provide details to any barriers encountered when making referrals to this service	

Section 6	Consent Statement for information sharing with the High Needs Panel

If you believe the client has consented to this referral via an alternative consent form, please provide proof of this consent here.

If you have not received the client's consent to be referred for consideration for higher support funding, please completed the following with the client.

I understand the information that is recorded on this form and agree to it being shared with the High Needs Panel for the purpose of providing services to me. I have agreed to sharing information with the services listed below.

Name | **Date**

Signed

Or

Verbal consent **Yes** ☐ **No** ☐

Audio consent attached **Yes** ☐ **No** ☐

Section 7	Additional Information Checklist	
Individual has provided consented to a referral to the High Needs Panel?		**Yes** ☐ **No** ☐
TH client engagement and Nomination form (attached)		**Yes** ☐ **No** ☐
HNP Budget: Required Support services and costs (attached)		**Yes** ☐ **No** ☐
VI-SPDAT Score provided		**Yes** ☐ **No** ☐

HNP use only: Date/time received

High Needs Panel

Budget Template

Individual Name		D.O.B		Date Referred	
Referring Agency		District		Choose an item.	

Current support package

Need	Intervention	Frequency	Service Provider	Fees per encounter/service

Additional package requirements

Need	Outcome criteria	Intervention	Frequency	Service Provider	Fees per encounter/service

Long term plan – transition to mainstream service provision

Goal	Action	Stage (by when)