



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									
Email									
Telephone						Date Referred			
<p>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.</p> <p>Name: Organisation Telephone Email</p>									
Engagement with frontline services									
Select ONE statement that best applies to the individual being referred:									
In the last month they:									
<input type="checkbox"/> Rarely missed an appointment.									
<input type="checkbox"/> Usually kept appointments and routine activities; followed through with reasonable requests, engaged in accessing other services.									
<input type="checkbox"/> Followed through some of the time with daily routines or other activities; sometimes followed through with reasonable requests; minimally involvement with other services.									
<input type="checkbox"/> Were irregular with routine activities or rarely engaged with reasonable requests, though kept some appointments.									
<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
Individual identifies as Aboriginal and/or/both Torres Strait Islander and over 45 yrs.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Individual identifies as LGBTQI+A	Yes <input type="checkbox"/> No <input type="checkbox"/>
Female	Yes <input type="checkbox"/> No <input type="checkbox"/>
Individual under 24 yrs.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Individual over 55 yrs.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Current living situation	
Rough Sleeping	Yes <input type="checkbox"/> No <input type="checkbox"/>
Temporary Accommodation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Transitional Housing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Housed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Living in overcrowded housing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (please provide details)	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
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 <input type="checkbox"/> No <input type="checkbox"/>
Mental Wellbeing	
Physical Health	
Substance Use	
Current risk to tenancy	

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

Section 5	Referral History
NDIS <input type="checkbox"/> Current <input type="checkbox"/> Previous referral	Provide details to any barriers encountered when making referral to this service
Mental Health <input type="checkbox"/> Current <input type="checkbox"/> Previous referral	Provide details to any barriers encountered when making referral to this service
HASI <input type="checkbox"/> Current <input type="checkbox"/> Previous referral	Provide details to any barriers encountered when making referral to this service
GP <input type="checkbox"/> Current <input type="checkbox"/> Previous referral	Provide details to any barriers encountered when making referral to this service
Drug & Alcohol Service <input type="checkbox"/> Current <input type="checkbox"/> Previous referral	Provide details to any barriers encountered when making referral to this service
Other <input type="checkbox"/> Current <input type="checkbox"/> 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.	
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	

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

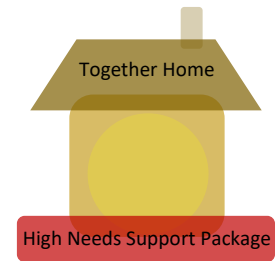
Audio consent attached Yes No

Section 7	Additional Information Checklist	
	Individual has provided consented to a referral to the High Needs Panel?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	TH client engagement and Nomination form (attached)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	HNP Budget: Required Support services and costs (attached)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	VI-SPDAT Score provided	Yes <input type="checkbox"/> No <input type="checkbox"/>

HNP use only: Date/time received

High Needs Panel

Budget Template



Individual Name		D.O.B		Date Referred	
Referring Agency		District			

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)