



Micah Projects Home for Good Referral Form

****** Please complete the form electronically and then save the form to your computer (using the 'save as' option). Then attach and email to homeforgood@micahprojects.org.au

Reason for Referral (tick all that apply)

Healthcare Homelessness Domestic violence Community support

Referral hospital details

Name of referral person and position _____

Name of referral hospital unit/department **(please attach hospital discharge summary)**

Phone _____ Email _____

Date of referral ____ / ____ / ____ Time of referral _____

Details of person being referred

Name of person _____

Hospital UR number _____

Anticipated date of discharge _____

Address at discharge _____

Contact phone (if applicable) _____ DOB ____ / ____ / ____

Gender Identity F M Transgender Intersex Declined to state

Medicare number (if known) _____

Consent Has the person you are referring consented to the referral? Yes No

Current reason for presentation/admission to hospital and existing medical conditions



Risk factors/alerts

Purpose of referral

Need for housing / accommodation

Is the person currently homeless? Yes No

Is the person at risk of losing their accommodation/housing while in hospital? Yes No

Does the person require accommodation? Yes No

If homeless—where did the person last reside? _____

What post-discharge housing options have been explored already?

Need for community services

Can the person return to their housing/accommodation but requires services? Yes No

What support does the person require from community services to return home?

Does the person currently have community services and/or health supports in place? Yes No

If yes—please briefly list _____

Does the person require community services to be discharged? Yes No

Has transport been arranged to get the person to their post-discharge housing or accommodation? Yes No

Need for healthcare

Does the person require access to ongoing medical treatment? Yes No

Does the person require assistance to manage their healthcare needs in the community? Yes No

Does the person require a visit prior to discharge to prevent re-admission or to reduce length of stay in hospital? Yes No

Have you attached the **discharge summary**? Yes No

If not, when will this key document be available please? _____

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Please attach Hospital Discharge Summary to ensure safe discharge and follow-up care.

