HOME FOR GOOD

Phone **3036 4444** or **3013 6093** | Fax 3029 7029
homeforgood@micahprojects.org.au

MICAH PROJECTS
Breaking Social Isolation
Building Community

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

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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? _____

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

Micah Projects Home for Good

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