

# Training Handbook for Homelessness and Health Workers

CBD HOMELESSNESS HEALTH ACCESS PROTOCOL



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This training was written by Maureen Dawson-Smith, Live Work Relate and Georgia Savage, INW PCP.

# SECTION 1

**This section includes the following topics:**

- Introduction to the *CBD Homelessness Health Access Protocol*
- Understanding the Relationship Between Health and Homelessness

**This section includes the following activities:**

*ACTIVITY ONE: Let's Talk about Health*

## SECTION 1: INTRODUCTION TO *CBD HOMELESSNESS HEALTH ACCESS PROTOCOL*

### **What is a Protocol?**

A protocol is an agreed way of working or an agreed practice which is shared by a number of workers. It usually identifies a number of steps, decisions, and options, but generally the aim of a protocol is to have one standard practice developed because it will get the best result for the client concerned.

### **Development of the *CBD Homelessness Health Access Protocol***

In 2009, a number of key homelessness and health services in the CBD acknowledged that there were significant barriers when referring homeless clients into health services. As a response, together they developed the *CBD Homelessness Health Access Protocol*, which is an agreed set of practices to improve access for homeless people to health services in the CBD of Melbourne. Working as the CBD Health and Homelessness Coordination Network, services signed off and committed to utilising the agreed upon Protocol.

All of these documents are available published on the INW PCP website <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/>

### **Training on how to use the Protocol**

To better understand and use the Protocol, a training handbook has been developed for frontline workers. It can be completed online at <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/> by those working in homeless and health agencies.

By going through this training handbook and completing the ten activities you will be able to:

- explain what the Protocol is, and understand how to use the tools to improve access to health services for homeless people
- explain the importance of your role in assisting particularly marginalised people to access health services
- provide information on the health services that are available for homeless people that offer health advice and support
- go through a written referral process.

## SECTION 1: UNDERSTANDING THE RELATIONSHIP BETWEEN HEALTH AND HOMELESSNESS

### *Key Messages for those using the Protocol*

#### **KEY MESSAGE FOR HOMELESS WORKERS**

The key message for CBD homeless workers is that health agencies which support the Protocol will give your referrals priority and work with you to ensure your clients get the services they need.

#### **KEY MESSAGE FOR HEALTH WORKERS**

The key message for CBD health services is that you are much more likely to engage and meet the health needs of homeless people by working with homeless workers.

#### **KEY MESSAGE FOR ALL**

The key message for both sectors is that by addressing health issues earlier, better health and housing outcomes can be achieved for homeless people in the CBD.

(1) Moreland and Hume's Health and Homelessness Network, Submission to the Homelessness 2020 Task Force, November 2009

### What is Health?

Health refers to the physical, mental and spiritual well being of an individual. The World Health Organisation's Ottawa Charter emphasises certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. These are often referred to as the 'social determinants of health'.

### What is homelessness?

#### Primary Homelessness:

People without conventional accommodation, e.g. living the streets, sleeping in derelict buildings, or using cars for temporary shelter.

#### Secondary Homelessness:

People who move from one form of temporary shelter to another, including homelessness services, rooming houses, and residing temporarily with friends.

#### Tertiary Homelessness:

People who live in boarding houses on a medium to long term basis <sup>(2)</sup>.

And/or has complex needs, defined as:

*A range of health conditions and behaviours - usually co-existing – that seriously limit the individual's ability to access services and/or to obtain and retain housing. These conditions include alcohol or drug dependence, mental illness, acquired brain injury, intellectual and other disability, age related frailty, and chronic health problems, with or without challenging behaviours <sup>(3)</sup>.*

(2) Chamberlain, C and MacKenzie, D., 2004 *Counting the Homeless 2001*, Victoria

(3) Howlett, K., 2003, *Better Health Care for People with Complex Needs in the CBD*, Moonee Valley Melbourne Primary Care Partnership

### ACTIVITY ONE: Let's Talk about Health

Imagine each individual in the photo has been living a homeless and transient life. Each individual is different and will require a different conversation about their health. What concerns would you have as a worker regarding the potential health issues for each client?

Photo A



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Photo B



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Photo C



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## SECTION 2

### **This section includes the following topics:**

- The Protocol in Action: A Case Study Approach
  - General Practitioner
  - Mental health
  - Women
  - Youth
  - Complex needs

### **This section includes the following activities:**

*ACTIVITY TWO: What Works when Making a GP Referral*

*ACTIVITY THREE: Service Coordination*

*ACTIVITY FOUR: Good Practice Guidelines*

*ACTIVITY FIVE: Prevention*

*ACTIVITY SIX: Getting Health Involved Earlier*



## SECTION 2: MENTAL HEALTH CASE STUDY

- (4) South East Health – *Homelessness and Human Services – A health Service Response* (2000)
- (5) (Dawson-Smith, 2008)
- (6) Council to Homeless Persons, *Submission to the Senate Enquiry into Mental Health*, (2005).
- (7) Buhrich N, Hodder P. and Teeson M. *Down and out in Sydney - the prevalence of mental disorders and related disabilities among homeless people in inner Sydney* (1998)
- (8) Kamieniecki, G. W. *Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review* (2001)
- (9) Hogan S. *Consultation on Mental Health Needs of Homeless People in CBD* (2006-7)



## SECTION 2: WOMENS CASE STUDY

### Working with Women who are Homeless:

Evidence suggests that many homeless women are escaping domestic violence or family breakdown, are likely to be at risk of a post-traumatic stress disorder and to have been victims of assault. Evidence also suggests this potential to experience violence continues whilst homeless. This suggests that any women's homelessness response needs to have active links with a Women's Health Service, the Centre Against Sexual Assault (CASA) and family violence services. Many women who are homeless report that they prefer to live rough than be placed in unsafe rooming houses or other congregate care living arrangements. Women experiencing primary homelessness are a minority group within the homeless population and often their needs are not met. The Royal Women's Hospital indicated that many women who are homeless do not undertake necessary preventive health checks such as breast and cervical tests. They also do not receive the necessary reproductive health service support they require throughout their reproductive years. The Royal Woman's Hospital identified it wished to form partnerships with community agencies to provide outreach women's health clinics to meet these needs <sup>(10)</sup>.

(10) Dawson-Smith, M., 2008, *Homelessness and Primary Health Service Coordination in the Melbourne CBD*, MVM PCP, Victoria

### Women's Case Study

*Zara arrives at a drop-in program and asks to see a support worker about 'women's' issues. Peta, the female support worker presents and introduces herself and role to the client and moves to client to a quiet room to discuss her needs. Zara discloses that she is residing at a boarding house and had recently been involved with a male resident, advising that they had unprotected sex on two occasions. She is concerned she may be pregnant, but is unsure how she feels about it. Peta provides information about reproductive health and discusses Zara's own awareness on sexual health. In response to Zara saying that she feels overwhelmed, Peta provides information about the Women's Hospital's programs:*

- 1. Women's Health Information Centre (telephone or walk-in);*
- 2. The Pregnancy Advisory Service (telephone and face to face service);*
- 3. The Well Women's Clinic (appointment only); and*
- 4. The Sexual Health Clinic (appointment only)*

*Peta also advises that Zara can make a self-referral by telephoning (or visiting) the Women's Health Information Centre on (03) 8345 3045 or 1800 442 007, or Peta could assist her in making a referral to link her in. Zara advises she is happy for Peta's assistance and Peta contacts the Women's Health Information Centre and asks for referral advice as to the best service for Zara, which in this case is the Sexual health Clinic. Peta make an appointment with the service, which Zara is happy about as "now they know my problem". Finally Peta checks that Zara has no difficulty in getting to the hospital but Zara lets her know she is ok as she has a Metcard. They look at the map together and Peta reminds her to tell her how it all went when she comes in next. Zara looks at bit nervous but smiles that she will. Once Zara has left, Peta fills out the necessary referral forms.*



## SECTION 2: YOUTH CASE STUDY

### Working with Children

Children who are homeless may have experienced trauma or violence in their former home settings and/or were living in often unsafe circumstances. Transience, isolation from family members, lack of consistent access to schools and friends all impact upon the health, wellbeing and development of a child. Children who are members of families with a history of trauma and/or inter-generational social exclusion may require specialist family support services, including parenting support services. Often these children need support to engage with children of their own age, particularly when they have been required to take on greater responsibilities for their siblings and parent's care.

The 2001, the Census recorded that approximately 56% of homeless people living in Melbourne's CBD were under the age of 25 years <sup>(11)</sup>. Youth who are homeless are most vulnerable to exploitation, violence and unsafe lifestyle conditions. Many youth enter homelessness through worn statutory and youth corrective pathways characterised by a history of grief, abandonment and trauma. Other homeless youth may be or are often struggling with issues of identity, including sexual identity, family relationships and troubled adolescence.

There is clear evidence that the experience of a homeless lifestyle can have severe adverse effects on young people. Project I <sup>(12)</sup> reported 10% as attempting suicide in the last three months, 30% reporting incidents of self harm, 26% of young homeless people reported a level of psychological distress indicative of a psychiatric disorder, 14% clinical depression, 12% clinical psychosis, 40% high risk alcohol consumption and 49% almost daily use of marijuana. They also concluded that these mental health issues may pre-date homelessness for approximately 50% of participants only. Finally, whilst 40% of those surveyed indicated that they believed they needed help with depression and anxiety, only 55% sought this assistance.

### Youth Case Study

*Linda is 17 years old and came to Frontyard Youth Services to get assistance with accommodation. In the process of uncovering her needs to Carolina, the youth worker also identified that Linda had no income stream, was sleeping rough, had recently had unprotected sex and was showing symptoms of anxiety and depression. Linda was subsequently referred to Melbourne Youth Support Services (MYSS), Centrelink and Young People's Health Service (YPHS). The MYSS engagement led to some crisis accommodation being established.*

*The engagement with YPHS amongst other things led to a Medicare card being issued which gave her identification that aided the Centrelink processing and an income stream. At the same time the HEADSS assessment tool that the YPHS staff member undertook with Linda led to some identifiable health outcomes and goals. Mental Health, Drug and Alcohol and Sexual Health are identified as the main issues in the Vulnerable Youth Framework discussion paper and in the course of her engagement with YPHS each of these issues along with some other issues were uncovered. Addressing the physical, mental, social and spiritual wellbeing of the client meant making some suggestions, and the client subsequently underwent a sexual health screen, received a Hep B vaccine and commenced her Gardasil schedule. She was happy in her current usage of alcohol but was made aware of services. Finally she chose to meet the Reconnect program worker at FY to seek to re-engage with her schooling, and some brokerage funding is being sought to allow her to re-engage with her family through a mediator.*

(11) Australian Bureau of Statistics, 2001, [http://www.ausstats.abs.gov.au/ausstats/free.nsf/Lookup/5AD852F13620FFDC CA256DE2007D81FE/\\$File/20500\\_2001.pdf](http://www.ausstats.abs.gov.au/ausstats/free.nsf/Lookup/5AD852F13620FFDC CA256DE2007D81FE/$File/20500_2001.pdf), retrieved April 2011

(12) Project I, 2003, *3 year study of 403 young homeless people in Melbourne and Los Angeles between 2001-3*, Victoria





## SECTION 3

**This section includes the following topics:**

- Myths about Health Service Referrals
- Barriers for Homeless People when Accessing Health Services
- Key Access Points in Health

**This section includes the following activities:**

*ACTIVITY SEVEN: A Quiz for Busting the Myths about Health Service Referrals*

*ACTIVITY EIGHT: Reflection on Barriers and Solutions for Homeless People when Accessing Health Services*

*ACTIVITY NINE: Key Access Points in Health*

## SECTION 3: MYTHS ABOUT HEALTH SERVICE REFERRALS

### **ACTIVITY SEVEN: A Quiz for Busting the Myths about Health Service Referrals**

*The Protocol also addresses some myths that exist within the community sector and health sector about making a referral to and receiving a referral in a health service. See how you go with this simple quiz with T (true) or F (false):*

1. *It is not the job of homelessness workers to be involved in health issues of clients.*  
**T/F**
2. *People who are homeless prefer to discuss their health issues with health workers only.*  
**T/F**
3. *Homelessness workers can make verbal referrals to health services that support the Protocol for their clients.*  
**T/F**
4. *Verbal referrals to health services have the same outcome as written referrals.*  
**T/F**
5. *Homelessness workers are not able to make referrals to health services that support the Protocol without written consent from their client.*  
**T/F**
6. *A homelessness worker cannot undertake a health initial needs identification (INI). It has to be a qualified health worker.*  
**T/F**
7. *Health services that support the Protocol are required to give priority of access to homeless people.*  
**T/F**
8. *Homelessness workers are not able to accompany clients to health appointments due to privacy issues.*  
**T/F**
9. *Health services are required to communicate with homeless services about the health status of their clients if they have received a written referral.*  
**T/F**
10. *The Protocol will stop all problems associated with making a referral and receiving a referral between health and homeless services.*  
**T/F**

## Answers to the Quiz:

### 1. ***It is not the job of homelessness workers to be involved in health issues of clients.***

**FALSE:** It is not true that simply because someone is homeless, they cannot address their own health issues independently, however there is a growing recognition that there are members of the homeless population who through living a homeless lifestyle are marginalised from mainstream services and need assertive support to access them. State and Commonwealth Homelessness Policy calls for a broader focus on health, wellbeing and housing outcomes in support plans to alleviate homelessness. One criterion under the 'Public Housing segmented priority waiting list' is the presence of health issues. Therefore, homelessness workers should liaise with health services to identify the health issues of each client and ensure they receive priority for public and community housing.

### 2. ***People who are homeless prefer to discuss their health issues with health workers only.***

**FALSE:** Some people who are homeless will not want to discuss their health issues with anyone other than a qualified health worker and where this is the case it is appropriate for case workers to respect their privacy and autonomy. However consultations with homeless peer representatives and workers have suggested that some homeless people experience such poor health and pain from untreated health conditions that it impacts upon their capacity to move on from being homeless. In this scenario, homelessness workers have the required engagement skills and empowerment practice to develop the right relationship of trust which can begin the dialogue "How are you feeling?" "I am worried about your arm which you seem to be holding... are you in any pain?" "Have you seen a doctor recently because I can help you to see one that I think is really OK?"

### 3. ***Homelessness workers can make verbal referrals to health services that support the Protocol for their clients.***

**TRUE:** The Protocol does not require homelessness workers to undertake a written referral. Verbal referrals are acceptable and accepted by health services that support the Protocol. When verbal referrals are made, the homelessness worker should liaise with a health worker who can follow through with ensuring the service is provided and your client's needs are met.

### 4. ***Verbal referrals to health services have the same outcome as written referrals.***

**FALSE:** Health services have told us that there is a better outcome for service access, treatment and follow up if they receive a written referral which is consistent with their own referral practice as there is greater monitoring and accountability. If homelessness workers provide a written assessment they will also be provided with information about the services then offered by the health service, thus improving service coordination.

### 5. ***Homelessness workers are not able to make referrals to health services that support the Protocol without written consent from their client.***

**FALSE:** One of the barriers identified by homelessness workers when making a referral to a health service is the belief that they must have written consent from clients before making that referral. This is not the case. Both health and community service workers share the view that where possible written consent should be obtained but in the case of working with those most marginalised in the

## Undertaking an Initial Needs Identification (INI) for a Health Referral

*The Summary and Referral Information Form* (appendix 4) can assist workers to identify their client's:

- initial health needs
- health and wellbeing risks
- network of agencies involved in support

If a homelessness worker uses this form, they will be provided with follow up information from the health service about any health issues that require a coordinated approach.

The provision of thorough health information assists with determining priority for getting a health service, managing client risks, and the better tailoring of services to individual needs.

If the referring worker does not or cannot complete the INI, they may choose to engage another service or worker better placed to do so. Where this is the case, they are advised to write “*not known*” in the relevant section of the document rather than leave it blank. This will ensure further follow up of this information by the health service at a later date.

homelessness community this is not always possible. This should not be used as a reason for failing to support individuals to get the health services they need. Therefore the Protocol states verbal consent for referral is adequate and that this verbal consent should be documented by the worker as a way of demonstrating that they have had this discussion with their client. More detailed information about client consent processes that have been agreed by both homeless and health sector agencies is provided on page 28.

### **6. A homelessness worker cannot undertake a health initial needs identification (INI). It has to be a qualified health worker.**

**FALSE:** Health services that support the Protocol encourage homelessness workers to undertake a health INI with their client. They acknowledge that homelessness workers have highly developed “engagement skills” and these skills may enable a more thorough identification of health and general needs. When homelessness workers use the appropriate documentation to make this needs assessment (appendix 4), they will be included in the information loop about further ongoing treatment requirements and health issues to be addressed. This will improve case planning coordination between health and homelessness services and hopefully improve outcomes for clients. This feedback from health services is also useful to assist homeless workers make the appropriate case for community housing.

### **7. Health services that support the Protocol are required to give priority of access to homeless people.**

**TRUE:** All health services that support the Protocol are required to review their service access policies to ensure that people who are homeless have priority and urgent access to the health services they need. Many of these services will also ensure that more flexibility is provided to people who are homeless, for example not requiring a fixed appointment or ensuring that arrangements are made to reduce waiting time at the service.

**8. *Homelessness workers are not able to accompany clients to health appointments due to privacy issues.***

**FALSE:** Health services that support the Protocol want people who are homeless to access their services. They acknowledge that those who are most vulnerable may need support from their key worker to make and attend these appointments. The health service will respect the wishes of their client in regards to whether they would like a homelessness worker to attend. Homelessness workers will maintain their practice of empowering their clients wherever possible.

**9. *Health services are required to communicate with homeless services about the health status of their clients if they have received a written referral.***

**TRUE:** One of the reasons why it is important to make a written referral and undertake an INI, if appropriate, is that the referral forms enable health services to report back to the referring agency about the treatments provided to the client. This dialogue between services will help people who are homeless to get the support they need to complete treatment as health and homelessness services are more coordinated and working together.

**10. *The Protocol will stop all problems associated with making a referral and receiving a referral between health and homeless services.***

**FALSE:** The Protocol in itself will not prevent problems occurring when making and receiving referrals, however over time consistent application will assist to change practice over time. Having the Protocol in place will enable agencies to work together to manage particular problems and identify and overcome barriers. One important reason for workers to use the agreed practice outlined in the Protocol is that they will not be alone in identifying service barriers. With the Protocol in place, the INW PCP will be able to monitor and reflect on the relationships and referrals between homelessness and health services. When issues arise when using the Protocol, there will be people in place to take further action on behalf of all services.

## SECTION 3: BARRIERS FOR HOMELESS PEOPLE WHEN ACCESSING HEALTH SERVICES

### Barriers to Access

The *CBD Homelessness Health Access Protocol* was developed by both homeless and health sector workers in response to the findings of a consultation process conducted in 2008 <sup>(14)</sup>.

These findings were that community service workers:

- Witness on a daily basis unnecessary suffering related to pain, chronic health conditions, mental health disorders and poor post acute health treatment follow up.
- Struggle to provide a holistic health and well being focus with very limited resources. Time is mostly spent in crisis management.
- As a consequence, find it difficult to gain an appropriate level of understanding of health issues related to homelessness and the health services available for referral.
- Spend considerable time establishing “trust” with their clients and know this trust is a fragile commodity. They are therefore reluctant to risk encouraging their clients to attend a service they do not know. Therefore a key determinate of making a referral was whether workers had an established relationship with the health worker or service.
- Have both good and bad experiences of primary health services, but generally struggle to understand why primary health services do not prioritise their referrals and deliver services in a more flexible and responsive way, sensitive to the lifestyle and personal issues of the person needing the service.
- Tend to make verbal referrals rather than written referrals. Most agencies do not use referral documentation or collect data on health service referrals.
- Value the principal of “client consent” to share information with other agencies but raised concerns that this very principle can be a barrier to making referrals if it is applied rigidly.

The Protocol includes two tools for workers to improve referrals. There is the:

- *Guidelines for Making Referrals to Health Services*, for homelessness workers, and;
- *Guidelines for Receiving Referrals in Health Services*, for the health services themselves.

The following activity will provide you with the opportunity to engage with these guidelines.

(14) Dawson-Smith, M., 2008, *Homelessness and Primary Health Service Coordination in the Melbourne CBD*, MVM PCP, Victoria

### **ACTIVITY EIGHT: Reflection on the Barriers and Solutions for Homeless People when Accessing Services**

*Think about the barriers that exist for homeless people in accessing health services. In column one, make a list of these.*

*Once this is done, read the **Guidelines for Making Referrals to Health Services** (see page 23) and the **Guidelines for Receiving Referrals in Health Services** (page 24) and fill in the remaining columns outlining how which of the guidelines supports you to overcome this barrier.*

**Table 1: Barriers for Homeless People when Accessing Services**

Barrier/s	Which of the Guidelines support you to overcome this barrier? (Making/Receiving)	What is the guideline?
<i>Difficult to engage homeless people in their health issues.</i>	<i>Making</i>	<i>1a, 4a, 4b and 4c</i>
	<i>Receiving</i>	<i>5 and 6</i>

# CBD Homelessness

## Health Access Protocol

### Guidelines for Making Referrals to Health Services

#### 1. Encourage the person who is experiencing homelessness to attend the health services they need by:

- a. identifying problems relating to attending appointments and working out ways to assist the person to attend;
- b. explain the service and how it works or get someone who can do this for you;
- c. talk through any expectations which may or may not be achieved;
- d. provide material aide to reduce barriers for attendance;
- e. seek consent to make the referral directly if the person cannot do this for themselves. (See section 6 of the Protocol); and
- f. ask how it went and be open to discussing any follow up appointments.

#### 2. In making a referral to an agency:

- a. ask about any protocol for priority of access;
- b. see if it is possible for the person to attend without an appointment;
- c. discuss needs, including longer appointments, gender issues;
- d. seek out a support/contact person within the service to assist;
- e. define your role with the service; and
- f. provide information to reduce duplicated questioning.

#### 3. In supporting someone's attendance to a health service:

- a. where appropriate, accompany or provide your contact details;
- b. follow up with service and/or person to ensure attendance;
- c. give feedback that will help the service to be more responsive to the needs of people experiencing homelessness; and
- d. attend /offer opportunities for workers to share practice.

#### 4. To ensure that you can support people who experience homelessness to care about their health:

- a. care about everyone's health and promote good health as a normal part of the work you do;
- b. if some one looks to be in pain or unwell ask the person if you can help them get some assistance;
- c. learn about health issues related to homelessness; and
- d. know the health services that are available to people experiencing homelessness in the CBD of Melbourne and the services that can assist in finding the right service.

# CBD Homelessness Health Access Protocol

## Guidelines for Receiving Referrals in Health Services

1. People experiencing homelessness are a priority target group. All staff within the service will have an understanding of appropriate pathway and responses for homeless people requiring services.
2. Reception/ front end staff are welcoming, accepting and understanding of the reality of homelessness for the individual.
3. Respect, acknowledge and where possible, cater for gender and cultural preferences throughout the provision of services by professionals.
4. Ensure tolerance toward any difficult behaviour and be flexible in providing sensitive ways to contain and address difficult behaviour.
5. Engage with the person, not the health issue and where possible designate someone with the service to build this relationship through ongoing support.
6. Provide a service which is of value at the time of first attendance.
7. Gauge whether the person is comfortable answering questions and, where necessary, change or stagger assessment practices to ensure ease of engagement.
8. Having received permission from the client, communicate openly and work collaboratively with the support people that are already available to the person experiencing homelessness.
9. Make sure time is spent with the individual working out the practical details and addressing any barriers to care.
10. Provide medication and treatment materials (where able) and follow-up that they are used appropriately.
11. Provide access to appropriate resources to assist clients in accessing support services.
12. Decide who will be responsible for:
  - Assertive outreach
  - Service follow up
  - Communication with referring agencies.
13. Be welcoming and pleased to see them when they present again.

## SECTION 3: KEY ACCESS POINTS IN HEALTH

### How to get advice about health and referrals: Key Access Points

A key feature of the *CBD Homelessness Health Access Protocol* is the role of health service providers who have agreed as part of this Protocol to act as a **key** across specific areas for opening health service doors to homeless individuals and/or their homelessness workers. In addition to providing their own health services, these agencies will act as a sounding board for homelessness workers to discuss health issues and referral options for their clients. To ensure that health agencies maintain this role and homelessness services know who to contact, we have named a number of agencies as key access points for particular health areas in the *Key Access Points in Health: A Quick Reference Guide*. There are 8 specific areas, each with 1-2 contact agencies.

Complete the activity below using the *Key Access Points in Health* on page 26.

### ***ACTIVITY NINE: Key Access Points in Health***

Using the photos below, look again at the potential health concerns of each individual. Now decide using the **Key Access Points in Health** on the next page, which agency you would contact to discuss the health concerns of these clients.

INDIVIDUAL	HEALTH CONCERNS	KEY ACCESS POINT
		
		
		

### Guide to Accessing Services

As well as these *Key Access Points in Health*, the *CBD Homelessness Health Access Protocol* includes a *Guide to Accessing Services*, which lists in full all the support, mental health, dental health, general health, drug and alcohol services and emergency services that operate in the CBD and can assist your homeless clients. It is a small A5 book, and is also available in electronic form at <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/>

## KEY ACCESS POINTS N HEALTH: A QUICK REFERENCE GUIDE

Area	Issues	Advice and Access Point	Contact
<b>MENTAL HEALTH CLINICAL</b>	<ul style="list-style-type: none"> <li>Crisis/Acute assessment - CAT Access</li> </ul>	<b>ROYAL MELBOURNE HOSPITAL</b> North Western Mental Health Centralised Triage – 24 hours	Phone: 1300 874 243
<b>MENTAL HEALTH NON CLINICAL</b>	<ul style="list-style-type: none"> <li>accessing short/long-term case mgt</li> <li>advice with referral into residential services</li> <li>daily living skills</li> </ul>	<b>COHEALTH</b>	Referrals via NEAMI central intake Phone: 1300 379 462
<b>DENTAL General Emergency Dentures Children</b>	<ul style="list-style-type: none"> <li>dental services</li> <li>health and health care service</li> <li>information</li> <li>discussing health issues</li> <li>initial written assessments and referrals</li> </ul>	<b>COHEALTH</b> 6 Gower St Kensington	Phone: (03) 8378 1670
<b>INDEPENDENT LIVING SUPPORT (Aged &amp; Disability)</b>	<ul style="list-style-type: none"> <li>aged care packages</li> <li>meals programs</li> <li>day programs/social support</li> <li>allied health</li> <li>daily living support</li> </ul>	<b>CITY OF MELBOURNE</b> (Aged Care Services) Level 3, Council House, 200 Little Collins Street, Melbourne	Phone: (03) 9658 9542 Ask for: Assessment and Intake Worker
<b>WOMEN'S HEALTH (sexual and reproductive health)</b>	<ul style="list-style-type: none"> <li>sexual and reproductive health</li> <li>cervical screening</li> <li>antenatal care</li> </ul>	<b>THE WOMEN'S HOSPITAL</b> Women's Health Information Centre, Corner Grattan Street & Flemington Road, Parkville	Phone: (03) 8345 3045 / Email: askeanursemidwife@thewomens.org.au Women can drop in - Ask for: Referral options and health information
<b>EMERGENCY &amp; HOSPITAL CARE</b>	<ul style="list-style-type: none"> <li>support in emergency/acute care</li> <li>post-care follow up</li> <li>health prevention</li> </ul>	<b>ST VINCENT'S HOSPITAL</b> Emergency Department / 24 hours Victoria Parade, Fitzroy	Phone: (03) 9288 2211 Ask for: Triage
<b>INJECTING DRUG USE AND ALCOHOL TREATMENT</b>	<ul style="list-style-type: none"> <li>GP health services</li> <li>pharmacotherapy prescribing</li> <li>multidisciplinary team</li> <li>biopsychosocial support</li> </ul>	<b>THE LIVING ROOM</b> 7-9 Hosier Lane, Melbourne	Phone: (03) 9945 2100 Ask for: Team Leader
	<ul style="list-style-type: none"> <li>GP specialist support</li> <li>self-care</li> <li>treatment programs</li> <li>prescriptions and dispensing</li> </ul>	<b>COHEALTH</b> HEALTH - DRUG SAFETY SERVICES -INNERSPACE 4-6 Johnson Street, Collingwood	Phone: (03) 9417 1299 Ask for: Team Leader – Harm Reduction Services or Team Leader Primary Health
<b>YOUTH HEALTH</b>	<ul style="list-style-type: none"> <li>youth health assessment, treatment and follow up</li> <li>specialist referrals</li> <li>health prevention and promotion</li> </ul>	<b>FRONT YARD YOUTH SERVICES</b> 19 King Street, Melbourne	Phone: (03) 9611 2411 Ask for: Youth Health Nurse
<b>HEALTH GENERAL</b>	<ul style="list-style-type: none"> <li>general health assessment</li> <li>assistance with medication</li> <li>outreach assessments</li> <li>wound treatment and after care</li> </ul>	RDNS HOMELESSNESS OUTREACH HEALTH NURSE located at <b>THE LIVING ROOM</b> 7-9 Hosier Lane, Melbourne	Phone: (03) 9945 2100 ask for RDNS HPP nurse in CBD
	<ul style="list-style-type: none"> <li>general medical &amp; nursing</li> <li>allied health</li> <li>social/welfare services</li> <li>outreach services</li> <li>Aboriginal health worker</li> </ul>	<b>COHEALTH</b> 75 Brunswick Street, Fitzroy	Phone: (03) 9411 3555
		<b>COHEALTH</b> 53 Victoria Street, Melbourne	Phone: (03) 9677 0800
<b>OUTREACH &amp; ABORIGINAL EYECARE SERVICES</b>	<ul style="list-style-type: none"> <li>eye examination</li> <li>eye health</li> <li>visual aids</li> <li>subsidised glasses</li> </ul>	OUTREACH SERVICES ABORIGINAL SERVICES <b>AUSTRALIAN COLLEGE OF OPTOMETRY</b>	Phone: (03) 9349 7472 - Ask for: Outreach Services, Aboriginal Services Email: outreach@aco.org.au Email: aboriginalservices@aco.org.au
<b>LEGAL</b>	<ul style="list-style-type: none"> <li>Legal advice and casework to people experiencing disadvantage who live, work or study in North Melbourne, West Melbourne, CBD, Docklands, Carlton &amp; Parkville</li> </ul>	<b>INNER MELBOURNE COMMUNITY LEGAL</b> 2/508 Queensberry Street, North Melbourne / 9am – 5pm	Phone: (03) 9328 1885

## SECTION 4

**This section includes the following topics:**

- Making a Referral
- Using Forms When Making a Referral
- Receiving Referrals in a Health Service

**This section includes the following activities:**

*ACTIVITY TEN: For Homelessness Workers*

*ACTIVITY ELEVEN: Receiving Referrals in a Health Service*

## SECTION 4: MAKING A REFERRAL

### The Protocol for Obtaining Client Consent

Both homeless and health providers share the fundamental practice principle that it is important to obtain client consent before making a referral. Paradoxically however, rigid “written consent” policies were identified as being a potential barrier to access for this vulnerable target group.

Those responsible for the development of the Protocol recommend that providers be encouraged to use the *Service Coordination Tool Template: Consent to Share Information* (See Appendix 1). This form can be downloaded from

[www.health.vic.gov.au/pcps/sctt.htm](http://www.health.vic.gov.au/pcps/sctt.htm) and can be used either electronically via email, using a secure messaging service such as ConnectingCare ([www.connectingcare.com](http://www.connectingcare.com)).

The following reasons were identified for making this recommendation:

- This *Consent to Share Information Form* is used by a large number of agencies.
- The procedure for good practice in obtaining “consent” is embedded in the documentation.
- The requirement for “written consent” is not mandatory.
- The form provides the evidence of verbal or written consent
- It may be that agencies have their own “Client Consent” forms and procedures. It is recommended they are reviewed to incorporate the essential elements of this *Consumer Consent to Share Information Form* so that the practice for ensuring client’s rights to decision making are protected in a way that does not provide a barrier for inter-agency referral.

### Referral Forms: The SCTT

The Victorian Government has developed a suite of referral tools called the *Service Coordination Tool Templates (SCTT)*. Using the SCTT can improve communication between health and homelessness service providers, the recording of information generated by screening and assessment processes, information sharing, and the quality of referrals and feedback. This can improve the health outcome for your client.

There are four pages from the SCTT form which are particularly relevant to those working in the homeless sector. These are:

1. *Consent to Share Information form*
2. *Referral Cover Sheet and Acknowledgement form*
3. *Consumer Information form*
4. *Summary and Referral Information form*

### Referral Options

There are three main referrals that can be made:

- a verbal referral
- a written referral to a single service
- a written referral to multiple services and/or for a complex client.

This next section of the training will assist you to understand when and how to make these referrals and use the appropriate forms.

### **Making a Verbal Referral**

You can encourage your client to make a telephone appointment to any health service which has signed up to this Protocol. This is best practice when your client is able, willing and capable of engaging with these services by themselves. However if your client does not have this confidence, you can offer to make the referral on your client's behalf and this will be accepted by the health service whether by telephone or in person. In this case you should fill out the *Consent to Share Information Form* and file it as proof that privacy procedures have been followed.

**DOCUMENTS NEEDED:** *Consent to Share Information Form (appendix 1) or own agency consent form.*

### **Making a Written Referral to a Single Service**

To improve health service referral procedures health services themselves have standardised referral documentation (the SCTT forms) and they have asked homelessness workers to use this documentation when making a written referral to a service. If the referral is just for one service and is not complex it is suggested you fill out the one page *Referral Cover Sheet*. Make sure that you tick that the appointment is urgent and you make sure you write that this referral is part of the *CBD Homelessness Health Access Protocol* in the 'other notes' section on the *Consent to Share Information Form*. This will ensure that your client gets the agreed priority access that all health services have agreed to give as part of the Protocol.

**DOCUMENTS NEEDED:** *Consent to Share Information Form (appendix 1) and Referral Cover Sheet (appendix 2)*

### **Making a Written Referral to Multiple Services and/or for a Complex Client**

Health services have indicated that using the same form for multiple health agencies achieves a better service access outcome for clients and ensures that services are better coordinated from the very beginning of treatment and support. If you are referring your client to multiple agencies you are encouraged to complete an INI using the *Summary of Referral and Information Form*. The text box on page 19 provides information on why and when it is beneficial for services to undertake an INI of the health needs of clients, and that by making this initial assessment, homelessness workers will be kept in on the information loop about treatment and follow up processes. The *Consumer Information Form* should also be completed when referring to multiple agencies or working with a complex client, as it allows the collection of further information that may be helpful for your client in obtaining the services they need.

You don't have to know all the answers to questions, but if you don't know, please write "not known" rather than leave blank. This will ensure that needs are further explored rather than ignored.

**DOCUMENTS NEEDED:** *Consent to Share Information Form (appendix 1) and Referral Cover Sheet & Acknowledgement Form (appendix 2); as well as the Consumer Information Form (appendix 3) and the Summary of Referral and Information Form (appendix 4)*

## SECTION 4: USING FORMS WHEN MAKING A REFERRAL

### Summary Forms Used When Making Referrals

Table 2 summarises what forms to use when making each referral, and why. Copies of the forms are also provided in the back of this training manual in the appendices. They can be printed off and used for each client either sent electronically or via fax. They can also be obtained from the INW PCP website at <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/>.

**Table 2: Recommended Use of Referral Forms**

Method of referral	Consumer Consent to Share Information Form	Confidential Referral Cover Sheet	Consumer Information Form	Summary and Referral Information Form (with INI)	Examples of when to use referral type
<b>Verbal referral</b>	✓ Important to have this document on referring agencies records. Health Services require consent to liaise with other services.				<p>Jim, 34, who is known to you and your service and "normally" enjoys good physical health, presents to your service with what appears to be an infected cut on his hand.</p> <p>Jim is not confident when speaking to new people over the phone as he has a stutter. On this instance you encourage Jim to see a GP and offer to call and make an appointment for him. Jim agrees to this action and consents to you calling his GP.</p>
<b>Written referral to a single service</b>	✓	✓ Indicate referral is part of the CBD Homeless Health Service Access Protocols in "Other Notes".			<p>Rachael, 24, presents to your service seeking emergency accommodation as has recently separated from her abusive partner.</p> <p>Throughout this discussion Rachel disclosed that she has had a number of panic attacks and would like to see a counsellor as has found this useful in the past while living interstate. Rachael agrees to referral to see a counsellor. A written referral is made to see a counsellor.</p>
<b>Written referral to multiple services and/or for a complex client</b>	✓	✓	✓ Do not leave information "blank" on consumer information form – rather write 'Not known'.	✓ This additional information assists with determining priority for services and better quality of initial care. Agencies may seek a "key health provider" to undertake the Initial Needs Identification.	<p>Evan, 43, presents to a meal service with no funds to purchase meal. Through having a discussion to arrange a meal "credit", Evan discloses that he has recently acquired a gambling problem and has a number of fines that require attention. Evan begins getting physically upset and discloses that his wife kicked him out of home 2 months ago and he is clearly distressed and depressed with his situation. To make matters worse, Evan was kicked out without being given his orthotics and is now experiencing significant pain through his right heel and hip.</p> <p>Evan agrees that there are a number of issues that require attention and agrees to work through the referral form.</p>
<b>Referring agency receiving feedback</b>		✓ Referral Acknowledgement included on form and is used as a tool to feedback information to referring agencies.		✓ Agency relationships mapping is essential for co-ordinated care.	

### **ACTIVITY TEN: For Homelessness Workers**

Section Two of this manual provides a number of case studies. Chose one of these case studies and imagine you are the worker responsible for filling out the **Consent to Share Information Form** (appendix 1), the **Referral Cover Sheet & Acknowledgement Form** (appendix 2) and **Summary and Referral Information Form** (appendix 4).

Remember that:

- services listed in the *Key Access Points in Health: A Quick Reference Guide* are available to assist you in filling out these forms.
- written referrals guarantee you will remain in the service loop and this is particularly important in ensuring health issues are identified in public and community housing applications.

In filling in the forms you should:

- identify the referral is urgent and is part of the CBD Homelessness Health Access Protocol for priority access in the 'other notes' section of the **Consent to Share Form**.
- write 'not known' for any question on any form rather than leave it blank. This will ensure that these questions will be further followed up by the health service at a later time.

## SECTION 4: RECEIVING REFERRALS IN A HEALTH SERVICE

### Receiving a Referral

As part of the Protocol, there are *Guidelines for Receiving Referrals in Health Services* (see page 24). Health services in this Protocol are required to ensure priority access for people who are homeless and improved communication with referral workers and agencies so that follow up treatment and be supported and completed. All health service workers, from reception to specialist workers are required to have an understanding of homelessness and its impact and be prepared to provide services in a more flexible way. This may include ensuring people do not need to wait inside the service or have a quiet area alone if they must wait at all. It may mean spending more time explaining health issues and treatment, or ensuring that follow up treatment can be provided by other health workers. The following exercise is designed to give you more time to familiarise yourself with the Protocol for receiving referrals and what this means for your role in practice.

#### ***ACTIVITY ELEVEN: Receiving Referrals in a Health Service***

*Choose one case study in Section 2 of this training manual and imagine or draw on your experience as a worker in a health service in Melbourne's CBD. You have received referral documentation from a worker in the homelessness sector for a client. Using the **Guidelines for Receiving Referrals in Health Services**, identify the key steps that you would take to ensure that this person received all the services they needed, in the right order, and with the appropriate follow up?*

*Practice in ensuring access to services*

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*Practice working with the client*

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*Practice to develop a treatment plan*

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*Practice working with homelessness sector to coordinate services*

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## SECTION 5

**This section includes the following topics:**

- What to do if you're having trouble using the *CBD Homelessness Health Access Protocol*: feedback and comments
- Evaluation
- Appendices
  1. Consent to Share Information Form
  2. Referral Cover Sheet and Acknowledgement Form
  3. Consumer Information Form
  4. Summary and Referral Information Form
  5. List of Homelessness and Health Agencies

## SECTION 5: WHAT TO DO IF YOU'RE HAVING TROUBLE USING THE CBD HOMELESSNESS HEALTH ACCESS PROTOCOL: FEEDBACK AND COMMENTS

### Having Trouble Using the *CBD Homelessness Health Access Protocol*?

When you try to use the *CBD Homelessness Health Access Protocol*, it may not always work in agencies and across the health and welfare sectors during the first stage of implementation. This Protocol relies on you to help with this implementation.

It will take time for agencies to ensure the guidelines and practices set out in the Protocol are in place for all staff as well as new staff coming on board. If you are having problems, here are some points that you can use to introduce them to the Protocol:

1. Identify that you work for an organisation that is using the *CBD Homelessness Health Access Protocol*, and ask a worker if they are aware of the Protocol.
2. If they are not aware of the Protocol, outline the some of the major points of the Protocol
  - *The Protocol aims to improve access for homelessness people in CBD to health services*
  - *It does this by setting out the agreed good practice for encouraging and supporting homeless people to use primary health services*
  - *It provides guidelines for making referrals and information on consent from your client*
  - *A number of services in the CBD have agreed to implement the Protocol, and all services should ensure they prioritise access for this vulnerable population.*
3. Request that the service, especially if they are listed in the Access Guide and/or Key Access Points, accept the referral and give it priority of access.
4. Refer them to <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/> for more information and background on the Protocol, noting there is training available at this site.

If you are still having difficulty, you can contact the services listed under the 'Key Access Points in Health', as they may be able to offer some practical advice or assistance in getting your referral accepted.

In general, when discussing the referral, ask workers from other organisations to engage with you about your client's problems and seek their support in coming up with solutions that work. Your approach to engaging with other services and workers will impact on how well you achieve the goal you want for your client.

### Feedback and Comments

Feedback on your experience using the *CBD Homelessness Health Access Protocol* can also be provided via a comments section on the INW PCP website at <http://inwpcp.org.au/resources/cbd-homelessness-health-access-protocol/>. These comments will be used to further develop and improve the Protocol so it is more usable for you, the worker, and achieves better outcomes for your homeless clients. If you come across an incorrect phone number in the Protocol, please let us know via the comments section, so that we can update the Protocol and keep it current.

## SECTION 5: EVALUATION

### Evaluation

As well as using the feedback as an evaluation tool, INW PCP will be conducting a survey of workers and agencies that provide services for homeless people in Melbourne's CBD to assess if and how the Protocol is being used. We would appreciate if you could take the time to complete this survey if it appears in your inbox, as it will help us improve the Protocol.

Findings from the survey and the comments will be provided to workers and agencies via the INW PCP website and networks, so make sure you keep a look out!

### Appendices

1. Consent to Share Information Form
2. Referral Cover Sheet and Acknowledgement Form
3. Consumer Information Form
4. Summary and Referral Information Form
5. List of Homelessness and Health Agencies

# 1. Consent to Share Information Form

<h2 style="margin: 0;">Consent to share information</h2> <p style="font-size: small; margin: 5px 0;">Purpose: to record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.</p>	<p><b>Consumer</b></p> <p>Name: _____</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex: _____</p> <p>UR Number: _____</p> <p style="text-align: center; font-size: small;">or affix label here</p>
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### Section 1: Personal/health information to be shared

Service Type <small>Examples:</small>	Name of Agency <small>Examples:</small>	Type of Information <small>Examples:</small>	Purpose/s <small>Examples:</small>
– physiotherapy – counseling	– Strawberry Community Health centre – Blueberry City Council	– all relevant information – exceptions as stated by consumer	– referral – shared care/case planning – informing services participating in consumer's care

### Section 2: Record of consent

**Written consumer consent**

*The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers, as above. I understand this and I give my consent for the information to be shared.*

Signed: \_\_\_\_\_

Dated (dd/mm/yyyy): / /

or

**Verbal consumer consent**

*I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.*

or

**Consumer does not have the capacity to provide consent**

(that is, they do not understand the nature of what they are consenting to, or the consequences)

Consent given by authorised representative \_\_\_\_\_  
(name of authorised representative)

There is no Authorising representative or they were uncontactable; therefore, the information will be shared as set out in the *Health Records Act 2001*\*

\*If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in the *Health Records Act 2001*. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

To ensure that the consumer's authorised representative can make an informed decision about consenting to the sharing of information as detailed above, the worker/practitioner should (tick when completed):

1. Discuss with the consumer the proposed sharing of information with other services/agencies
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed
3. Provide the consumer with information about privacy, such as the brochure *Your Information – It's Private*
4. Provide the consumer with a copy of this form once completed.

Produced by the Victorian Department of Health, 2012

<b>Consent obtained/witnessed by:</b>		CSI Page 1 of 1
Name: _____	Position/Agency: _____	
Sign: _____	Date: dd/mm/yyyy / /	Contact number: _____

Consent to Share Information

## 2. Referral Cover Sheet and Acknowledgement Form

<h3 style="margin: 0;">Referral cover sheet and acknowledgement</h3> <p style="font-size: small; margin: 5px 0 0 0;">Purpose: to send with a referral or to acknowledge receipt of a referral.</p>	<p><b>Consumer</b></p> <p>Name: _____</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex: _____</p> <p>UR Number: _____</p> <p style="text-align: center; font-size: small;">or affix label here</p>
--	---

Date: dd/mm/yyyy / /

### Referral

To send a referral complete this section									
<b>From</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> <tr><td colspan="2">Role with consumer:</td></tr> </table>	Name:	Position:	Organisation:	Phone:	Email:	Fax:	Role with consumer:	
Name:	Position:								
Organisation:	Phone:								
Email:	Fax:								
Role with consumer:									
<b>To</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table>	Name:	Position:	Organisation:	Phone:	Email:	Fax:		
Name:	Position:								
Organisation:	Phone:								
Email:	Fax:								
Referral for type of service/service requested: _____									
Priority: <input type="checkbox"/> urgent (list reason in notes) <input type="checkbox"/> non-urgent									
SCTT attached: <input type="checkbox"/> consumer information <input type="checkbox"/> summary and referral information <input type="checkbox"/> other (list)	Other documents attached: <input type="checkbox"/> assessment information/report <input type="checkbox"/> care plan <input type="checkbox"/> other (list)								
Notes: _____									

Referral cover sheet and acknowledgement

### Acknowledgment

<input type="checkbox"/> To acknowledge a referral you have received, complete this section																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"><b>From</b></td> <td> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table> </td> </tr> <tr> <td><b>To</b></td> <td> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table> </td> </tr> </table>	<b>From</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table>	Name:	Position:	Organisation:	Phone:	Email:	Fax:	<b>To</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table>	Name:	Position:	Organisation:	Phone:	Email:	Fax:
<b>From</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Name:</td><td>Position:</td></tr> <tr><td>Organisation:</td><td>Phone:</td></tr> <tr><td>Email:</td><td>Fax:</td></tr> </table>	Name:	Position:	Organisation:	Phone:	Email:	Fax:									
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Name:	Position:															
Organisation:	Phone:															
Email:	Fax:															
Date referral received: dd/mm/yyyy / /																
Status of referral: <input type="checkbox"/> accepted <input type="checkbox"/> wait listed <input type="checkbox"/> rejected (note reason and suggest alternatives)																
Estimated date of assessment: dd/mm/yyyy / /																
Contact person for further information: <input type="checkbox"/> as above (from details) <input type="checkbox"/> new contact (provide in notes)																
Notes: _____																

Practitioner signature: _____ Position: _____ Contact (phone/email): _____	Total number of pages sent: _____
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### 3. Consumer Information Form

## Consumer information

Purpose: to collect common demographic and other essential consumer information that can be shared with another agency.

**Consumer**

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

  

**Consumer details**

**Family name:** \_\_\_\_\_

Given names: \_\_\_\_\_

Preferred name/s: \_\_\_\_\_

Date of birth: dd/mm/yyyy / /

Is the date of birth estimated? Code:

Gender: Code:  Title: \_\_\_\_\_

Home address \_\_\_\_\_

Post code: \_\_\_\_\_

Postal address (if different from above): \_\_\_\_\_

Post code: \_\_\_\_\_

**Contact phone numbers** (tick preferred number) Post code: Can leave message?

Home: ( )  Yes  No

Work: ( )  Yes  No

Mobile:  Yes  No

Email:  Yes  No

Are you a carer or care recipient? Code:

**Employment/student status** Code:

Comments: \_\_\_\_\_

Country of birth: \_\_\_\_\_ Code:

Indigenous status: \_\_\_\_\_ Code:

Are you of Aboriginal and/or a Torres Strait Islander origin? \_\_\_\_\_

Refugee status:  Yes  No  Not stated/unknown

If yes, year of arrival: \_\_\_\_\_

Need for interpreter services: \_\_\_\_\_ Code:

Preferred language: \_\_\_\_\_ Code:

Communication method: \_\_\_\_\_ Code:

**General Practitioner (GP)**

GP name: \_\_\_\_\_

Practice name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Who the agency can contact if necessary**

*(for example, carer, parent, next of kin, guardian, friend, emergency contact, case manager, support worker)*

**Contact 1 Name:** \_\_\_\_\_

Address \_\_\_\_\_

Post code: \_\_\_\_\_

Phone numbers

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship to consumer: \_\_\_\_\_ Code:

**Contact 2 Name:** \_\_\_\_\_

Address \_\_\_\_\_

Post code: \_\_\_\_\_

Phone numbers

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

Relationship to Consumer: \_\_\_\_\_ Code:

**Government pension/benefit status:** Code:

If on a disability support pension nature of disability: \_\_\_\_\_ Code:

**Health care card holder status:** Code:

Card number: \_\_\_\_\_

**Medicare card & status:** Code:

Card number: \_\_\_\_\_

**Health insurance status:** Code:

Insurer name: \_\_\_\_\_

Card number: \_\_\_\_\_

**DVA card entitlement:** Code:

DVA card type: \_\_\_\_\_

DVA card number: \_\_\_\_\_

**Compensable funding source:** Code:

Comments \_\_\_\_\_

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CI pg 1 of 1

This information collected by:

Name: \_\_\_\_\_ Position/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: dd/mm/yyyy / / Contact number: \_\_\_\_\_

Consumer Information

## 4. Summary and Referral Information Form

### Summary and referral information

Purpose: to record and share a summary of the consumer's presenting and identified issues and other information to assist in a referral.

#### Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

#### Alerts

Allergies:	
Risks: (attach any available risk assessments)	Code: <input type="text"/>
Risk management strategies:	
There are concerns that the consumer is not capable of making their own decisions	Code: <input type="text"/>
Enduring powers of attorney are in place	Code: <input type="text"/>
Access to the referred service has been discussed with the consumer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Barriers to Service: _____	
Support required to address barrier to service: _____	

#### Current services

Services used in the last twelve months. Consider all health and community services.

Agency	Service type Code:	Record contact details or other information as appropriate (eg key contact)

#### Referrals sent

Agency	Service type Code:	Contact details	Purpose of referral	Feedback required

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This information collected by:		SRI Page 2 of 2	
Name:	Position/Agency:		
Sign:	Date: dd/mm/yyyy / /	Contact number:	

Summary and referral information

## 5. List of Homelessness and Health Agencies

The homelessness and health agencies listed below have all agreed to adopt and enact the *CBD Homelessness Health Access Protocol* and the various Guidelines which sit underneath it (current in September 2011).

These are:

Alfred Homeless Outreach Psychiatry Service (HOPS) / Inner South East Mental Health Service

Australian College of Optometry

Centre Against Sexual Assault (CASA House)

City of Melbourne

Clarendon HOPS/ Inner Urban East Mental Health Service

cohealth

Council to Homeless Persons

Department of Health

Department of Human Services

Frontyard Youth Services, Melbourne City Mission

Homeground

Inner North West Melbourne Medicare Local

Inner North West Primary Care Partnership

InnerSpace, cohealth

Inner West Area Mental Health Service

Living Room Primary Health Service, Youth Projects Inc.

North Richmond Community Health Centre

North West Housing Network

Macedon Ranges and North Western Melbourne Medicare Local StreetHealth

Ozanam Community Centre, VincentCare

Royal District Nursing Service Homeless Persons Program

St Vincent's Hospital ALERT program

The Lazarus Centre, Anglicare

The Royal Dental Hospital of Melbourne, Dental Health Services Victoria

The Royal Melbourne Hospital (Emergency Department)

The Salvation Army, Project 614

The Women's

Travellers Aid

Urban Seed

Women's Domestic Violence Crisis Centre

Young People's Health Service, Centre for Adolescent Health, Royal Children's Hospital

Youth Support and Advocacy Service