inclusive health
PARTNERSHIPS IN HEALTHCARE FOR ALL

HOMELESS TO HOME HEALTHCARE
AFTER HOURS SERVICE

7 days | 6pm - midnight | Brisbane wide
Ph 3036 4444 | Fax 3029 7029
Micah Projects, PO Box 3449, South Brisbane Q 4101
healthcare@micahprojects.org.au | www.micahprojects.org.au

Homeless to Home Healthcare After Hours Service
Initial Referral Information

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

Referring Agency Details

Name of Referring Agency _____

Name of Referring Worker _____

Phone _____ Email _____

Date of Referral ____ / ____ / ____ Time of Referral _____

Details of Person Being Referred

Name of Person _____

Address _____

Client Phone (if applicable) _____

DOB ____ / ____ / ____ Gender ☐ M ☐ F

Consent

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

Medicare Number

(if known) _____

Reason for Referral

Any Specific Clinical Instructions

>>
continued over page

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? _____

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 health care 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

** *NB: Please attach Hospital Discharge summary to ensure safe discharge and follow up care.*