DISABILITY LIAISON SERVICE REFERRAL FORM

	Identify	Referral Date	/ /
		Referrer details (inc. role, dept/program, contact number, email)	
		Patient UR Number	
		Patient Name	
		Patient Address	
		Patient Date of Birth	/ /
		Gender	☐ Female ☐ Male ☐ Other
		Is the patient of Aboriginal or Torres Strait Islander Background?	☐ YES ☐ NO If so, which?
		Is the patient of a Non-English Speaking Background (NESB)?	☐ YES ☐ NO If yes, what is the patient's first language?
		If a consultation is recommended, is an interpreter, or other assistance with communication required at the consultation?	☐ YES ☐ NO If yes, what assistance is required?

S	**Situation**	Social situation	☐ Alone ☐ With family ☐ With others ☐ Residential service
		Next of Kin (including relationship and phone number)	
		Has the access to the referred service been discussed with the consumer or their representative, and Consent for Referral obtained?	☐ YES ☐ NO
		Name, address and contact details of GP	
B	**Background**	Relevant health history including behavioural/psychiatric history (if any)	

A	**Assessment**	Reason for referral	☐ COVID-19 testing access ☐ Behaviour related ☐ Psychosocial related ☐ Function related ☐ Carer related ☐ Medication related ☐ NDIS related ☐ Community supports related ☐ Assessment/treatment related ☐ Accommodation related ☐ Specialist Support ☐ Other
		Please provide further details	
		Is the person currently an inpatient or at risk of hospital admission or ED presentation?	☐ YES ☐ NO
		Is there a risk of significant harm to self or others or relinquishment of care?	☐ YES ☐ NO
		Does the person require COVID-19 testing?	☐ YES ☐ NO
R	**Request**	Prioritisation	☐ Within 24 business hours ☐ Within 5 business days ☐ Within 10 business days

Name	
Designation	
Signature	
Date	/ /

PLEASE FORWARD ALL COMPLETED REFERRALS TO: disability_liaison@monashhealth.org
(Subject of email: DLO Referral)
Any concerns or questions related to this referral please call 0407 432 106 or 0400 183 551 to discuss further.