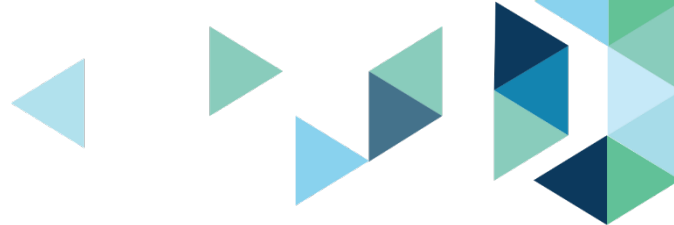
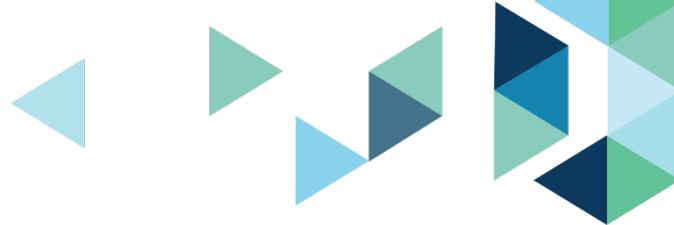


# COVID Home Isolation Support Service (CHISS)



REFERRER DETAILS		Date of Referral	
Title & First Name	Last Name		
GP Practice/Organisation	Provider #		
Address			Post Code
Phone No.	Email		
Fax No.	HealthLink EDI		
PATIENT / CLIENT DETAILS		Time & Date of Isolation Commencement	
		am/pm	/ / 2022
First Name	Date of Birth		
Last Name	Preferred Name		
Address			Post Code
Phone No.	Email		
Consent to referral	<input type="checkbox"/> YES – patient has indicated their consent	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Who PCCS can contact, if necessary (e.g., Carer, parent, next of kin, guardian, friend, emergency contact, case manager, support worker)			
Name	Phone	Relationship	
ELIGIBILITY & RELEVANT INFORMATION (Please tick all that apply)			
<input type="checkbox"/> YES – Client has tested positive for COVID-19 and is required to isolate at home OR is otherwise required to isolate at home <b>AND ONE OR MORE OF THE FOLLOWING</b> <input type="checkbox"/> YES – Client may be at low risk of mental ill health or has general health comorbidities <input type="checkbox"/> YES – Client is experiencing social isolation or lack of connection			
Primary Diagnosis	Other Relevant Diagnoses or Issues*	Other Services Involved	
Current Medication			
*You can also provide relevant plans/attachments			
REASON FOR ISOLATION SUPPORT & ADDITIONAL AREAS OF SUPPORT RECOMMENDED			
<input type="checkbox"/> Emotional Wellbeing	<input type="checkbox"/> Social Connection	<input type="checkbox"/> Housing or Social Supports	<input type="checkbox"/> Families & Relationships
<input type="checkbox"/> Physical Health / ADLs	<input type="checkbox"/> Food, Diet, or Lifestyle	<input type="checkbox"/> Financial Needs & Benefits	<input type="checkbox"/> Domestic Violence
		<input type="checkbox"/> Employment & Education	<input type="checkbox"/> NDIS & My Aged Care
<b>Goals of Support</b> - What are the main opportunities/goals? - What can we assist with? - Any other relevant information			



## KEY RELEVANT ISSUES (what else do we need to know and what should we avoid)

Description of key presenting or underlying issues of relevance to this referral or other relevant information (e.g., cultural needs; medical; medication issues; developmental, functional; living skills; social; emotional; trauma, abuse and neglect; etc.)

**SAFETY ALERTS** - Are there any risk factors we should be aware of when meeting with or visiting the client? For example if there is a history of aggressive behaviour?

*Please tick all that apply.*

YES – please provide details below or attach risk assessment   
  NO   
  UNKNOWN

Risk of harm to self   
  Risk of harm to other   
  Mental Health Order

Enduring Power of Attorney   
  Not able to make own decision / Guardianship

Orders relating to children   
  Intervention Order / AVO   
  Triggers / Trauma

## CURRENT RISK OF HARM

0 – No identified risk   
  1 – Low risk   
  2 – Moderate risk   
  3- High risk

**\*\*4 – very high risk (e.g., current suicidal ideation and plan OR long term history of dangerous behaviour OR current severe or disorganised thinking OR other imminent risks to wellbeing) – Please contact the Mental Health Access Line on 1800 011 511.**

## ADDITIONAL CLIENT INFORMATION

Country of birth		Primary language	
Refugee Status	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	Communication or support required?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aboriginal	<input type="checkbox"/> YES <input type="checkbox"/> NO	Please specify any specific patient supports required	
Torres Strait Islander	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If needed - tick both)</i>		
Does the person have caring responsibilities?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	Does the client have a disability or long term health condition?	<input type="checkbox"/> Long Term Health Condition <input type="checkbox"/> Disability <input type="checkbox"/> Frequent Attendance
Employment status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Pension	Please provide details of long term health conditions.	
CRN (Centrelink)		Recent Hospitalisation	<input type="checkbox"/> YES (Previous 12 Months) <input type="checkbox"/> NO

## WHAT IS COVID HOME ISOLATION SUPPORT (CHIS)?

**COVID Home Isolation Support** is a short-term service (up to two weeks) supporting people to access non-clinical, local, community based services to aid their wellbeing while they are required to isolate at home for a period of time as determined by the NSW Department of Health. These patients are eligible for this service if they are also experiencing social isolation or lack of connection, and low risk mental health or general health comorbidities, such as:

- People living with long term mental health issues and other chronic diseases
- People experiencing social isolation, depression or anxiety
- People who have had major life events such as loss of a partner, job, or house
- People wanting more physical activity or needing better access to healthy foods
- People more at risk of poor health outcomes associated with social determinants of health

Our team of **Social Workers** can assist patients to find supports, like assisting with **Support to Access Services** such as help with applications for Centrelink emergency payments and other social and welfare services; **Daily Living and Lifestyle Needs** like grocery shopping and prescription delivery, and online or phone based activities that promote health and wellbeing; and **Connecting Between Health Professionals** to meet or escalate healthcare requirements, and assist coordination of appointments.

**RETURN REFERRAL TO:**  
 HealthLink EDI: gpsocial    email: [nswintake@pccs.org.au](mailto:nswintake@pccs.org.au)    Fax: 1300 067 747    Or Call Us On (02) 9477 8700