Sunnysights Independent Living ABN 31 651 264 658

Exit and Transition Form

Your Details	
Client First Name:	
Client Last Name:	
Client Date of Birth:	

Representative or Emergency Contact Details	
First Name	
Last Name	
Relationship to Client	

About you	
Living Situation	☐ Own home (alone) ☐ Own Home (with family) ☐ Supported Accommodation ☐ Temporary ☐ Other: _____
Aboriginal or Torres Strait Islander descent?	☐ Yes ☐ No
Does the Client have a current Behavioural Support Plan	☐ Yes ☐ No
Primary Formal Diagnosis	
Secondary Formal Diagnosis	

Any allergies? If yes please provide below	
Medical diagnosis and medicine that may affect the support provided	
Name and contact number for Client's Doctor	
Any legal issues that may affect service eg. Apprehended Violence Order	

Communication	
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other: _____
Is the Client of a culturally or linguistically diverse background?	☐ Yes ☐ No Details:

Languages Spoken	☐ English ☐ Other: _____
Is an Interpreter required?	☐ No ☐ Hearing Impaired ☐ Language

Mental Health			
I have/experience...			
☐	Depression	☐	Anxiety
☐	Psychosis	☐	Schizophrenia
☐	Bipolar	☐	Other
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			
☐	Sunnysights Independent Living may provide a copy of any relevant management plans to any new provider.		

Physical Health			
I have...			
☐	Diabetes	☐	Sleep Apnoea
☐	Epilepsy	☐	Dietary Needs
☐	Asthma	☐	Blood Disorders

☐	Visual Impairment	☐	Hearing Impairment
☐	Cognitive Impairment	☐	Heart Conditions
☐	Allergies to:		
☐	Other:		
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			
☐	Sunnysights Independent Living may provide a copy of any relevant management plans to any new provider.		

Transition Risks	Comments	Strategies	Who is responsible?	Monitor and Review

Consent

The Client consents to Sunnysights Independent Living:

(a) providing and discussing your Plan with any new providers of your supports and services identified by you to us to enable a planned and documented transition of supports
(b) discussing you (including any risks associated with transitioning your care) with any new providers of your supports and services identified by you to us to enable a planned and documented transition of supports
(c) releasing copies of your all existing records relating to such supports and services (except for those records which Sunnysights Independent Living is not required to release under applicable law)

Signed by the Client:

……..……..
Signature

……..……..
Name (please print)

Signed by the Representative:

……..……..
Signature

……..……..
Name (please print)