

# REFERRAL FORM

## Community Options

GPO Box 3067  
Canberra ACT 2601

Ph 02 6295 8800

Fax 02 6295 8100

### CLIENT DETAILS:

Date:

Full Name - Mr/Mrs/Ms:

Address:

Postcode:

Telephone: (H)  (W)  (M)

Date of Birth:  Age:  Male or Female:

Lives Alone? Yes  No  Specify

Home Owner  Private Rental  Public Rental  Other

Name of contact person:

Relationship to client:  Contact Ph:

Next of Kin or second contact:

Relationship to client:  Contact Ph:

Income type:  DVA: Yes  (Card Colour)  No

Country of Birth:  Aboriginal/TSI Yes  No

Able to Communicate? Yes  No  Specify

### RELEVANT HEALTH AND SOCIAL ISSUES:

### TYPE OF SUPPORT REQUESTED: (also specify frequency and anticipated length of support)

### OTHER SERVICES THAT WILL BE INVOLVED WITH CLIENT:

GP / SPECIALIST:  PH:

**REFERRING AGENCY AND OTHER DETAILS:**

Client's name:

Name of person sending referral:

Position:

Signature of referrer:

Organisation:

Contact Ph:

FAX:

**Referrer may have had a pre-referral discussion with a Community Options coordinator prior to sending a referral:**

Referral discussed with:  Date of Contact

(Community Options Coordinator)

Indicate if any of the following are current issues with the client:

Mobility: YES  NO  specify

Falls: YES  NO  specify

Incontinence: YES  NO  specify

Wounds: YES  NO  specify

Any Others? YES  NO  specify

ACAT Assessment: YES  NO

OT Assessment: YES  NO

Date of ACAT Assessment:

Date of OT Assessment:

Other assessments:

Future Care Plan/Other comments:

**This consent authorises Community Options to use information in this referral for the purpose of planning, organising and delivering services, as requested.**

**Written Consent**

From:

Client  Carer  Guardian

**Verbal Consent**

From:

Client  Carer  Guardian

Verbal Consent obtained by:

(Name)

Signature:

Date:

## **CARER'S DETAILS**

Name

Address

Phone

Postcode

Gender - M / F

DOB

Age

Relationship to client

Live in - YES / NO

Length of time in caring role

Country of Birth

Aboriginal / TSI - YES / NO

Non-English speaking culture - YES / NO

Language / communication assistance required - YES / NO

Carer's health problems / disability - YES / NO If YES, specify

## **CARER'S INCOME / EMPLOYMENT STATUS**

Pension Type - Age / Disability / Carer / DVA / Unemployment

OTHER INCOME SOURCE:

Carer's allowance (DNCB) - YES NO

## **CARE RECIPIENT'S INCOME / EMPLOYMENT STATUS**

Pension Type - Age / Disability / Carer / DVA / Unemployment

OTHER INCOME SOURCE:

Comments