

REFERRAL & INTAKE FORM

Please complete all relevant sections each time a request is made for counselling

CASE NUMBER	New Client	Previous Client	Couple / Family Counselling Case Numbers	
<input style="width:100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

REFERRAL DETAILS

DATE OF REFERRAL

REFERRER'S NAME

POSITION

ORGANISATION

ADDRESS

CONTACT NO

REFERRER'S EMAIL

SOURCE OF REFERRAL

1. Self

2. Family, friend, significant other

3. Carer Advisory Service

4. CRCC

5. Aged or disability assessment service

6. HACC Assessment authority

7. Community Nursing service

8. Acute care hospital

9. Psychiatric / mental health facility

10. Other

99. Not stated / inadequately described

SUMMARY OF CARER'S CURRENT ISSUES

Is the referral urgent: Yes No

Reason

CARER DETAIL

Individual **Couple/Family** **or** **Group counselling**
For couple/family counselling complete name of other members at bottom of page

FIRST NAME

SURNAME

RESIDENTIAL ADDRESS

POSTAL ADDRESS (if applicable)

CONTACT NUMBERS *Is it ok to leave a message?*

HOME Yes No

WORK Yes No

MOBILE Yes No

MOST CONVENIENT TIME TO CALL

EMAIL

FULL DATE OF BIRTH

GENDER: Male Female Not stated

CALD STATUS

COUNTRY OF BIRTH

CULTURAL IDENTITY

FIRST LANGUAGE (other than English)

INTERPRETER REQUIRED? Yes No

ATSI STATUS

1. Aboriginal or Torres Strait Islander

2. Neither Aboriginal nor Torres Strait Islander

99. Not stated

COUPLE/FAMILY COUNSELLING DETAILS (other members attending)

1. NAME

Relationship to care recipient

2. NAME

Relationship to care recipient

CARER DETAILS (continued)

CARER RECEIVING GOVERNMENT INCOME SUPPORT PAYMENT

(Tick any that apply)

- 1. Age pension
- 2. Veterans' Affairs pension
- 3. Disability support pension
- 4. Carer payment
- 5. Carer allowance
- 6. Unemployment related allowance
- 7. Other government pension / allowance
- 8. No government income support payment
- 99. Not stated / inadequately described

EMPLOYMENT STATUS

- 1. Full time employed
- 2. Part time employed
- 3. Not in paid employment
- 4. Unemployed related allowance
- 5. Retired
- 99. Not stated

CARER'S RELATIONSHIP TO CARE RECIPIENT

- 1. Wife / female partner
- 2. Husband / male partner
- 3. Mother
- 4. Father
- 5. Daughter
- 6. Son
- 7. Daughter in law
- 8. Son in law
- 9. Other female relative
- 10. Other male relative
- 12. Male friend / neighbour
- 99. Not stated / inadequately described

NUMBER OF CARE RECIPIENTS

- 1. 1 care recipient
- 2. 2 care recipients
- 3. 3 care recipients
- 4. More than 3 care recipients

LENGTH OF TIME AS CARER

- 1. Less than 2 years
- 2. 2 — 4 years
- 3. 5 — 9 years
- 4. 10 — 24 years
- 5. More than 25 years

CARER STATUS

- 1. Primary carer
- 2. Other carer

PRIMARY TRIGGER FOR SEEKING CARER SUPPORT

- 1. Recent commencement of caring role
- 2. Death of care recipient
- 3. Negative change in condition of care recipient
- 4. Negative change in health of carer
- 5. Employment issues
- 6. Care recipient moved to residential care
- 7. Financial strain
- 8. Change in household composition
- 9. Ongoing stress of carer role
- 99. Other / not stated

CARE RECEIPT DETAILS

AGE OF CARE RECIPIENT

- 1. Younger than 8
- 2. 8 — 12
- 3. 13 — 15
- 4. 16 — 18
- 5. 19 — 21
- 6. 22 — 25
- 7. 26 — 35
- 8. 36 — 45
- 9. 46 — 55
- 10. 56 — 65
- 11. 66 — 75
- 12. 76 — 85
- 13. Older than 86
- 99. Not stated

DOMESTIC ARRANGEMENT

- 1. Living with care recipient
- 2. Not living with care recipient
- 3. Not indicated
- 4. Not applicable

SUBURB / TOWN _____

POSTCODE OF CARE RECIPIENT _____

CARE RECIPIENT GROUP (Tick all that apply)

- 1. Carers of frail aged (65+ or 50+ for indigenous)
- 2. Carers of people with dementia
- 3. Carers of young people (under 65) with a disability
- 4. Carers of people with a chronic illness
- 5. Carers of people in need of palliative care
- 6. Carers of people with a mental illness

Specify condition/Diagnosis

SIGNATURE OF PERSON COMPLETING FORM

CARER CONSENT

I consent to my information being provided to the carer counselling program victoria for the purposes of referral and assessment for counselling services and inclusion in de-identified data reporting.

SIGNATURE OF CARER

OR VERBAL CONSENT OBTAINED BY:

NAME _____

DATE OF VERBAL CONSENT _____

Mail to:

NCCP
Carers Victoria
PO Box 2204
FOOTSCRAY VIC 3011
Email: nccpadmin@carersvic.org.au

Fax to:

(03) 9396 9595

For referral enquiries ring the Carer Advisory Line on 1800 242 636