

Confidential Referral Cover Sheet

Date Sent: dd/mm/yyyy / /

Number of Pages (including cover sheet):

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Referral to

Name:

Position:

Organisation:

Phone:

Fax:

Email address:

Address:

Agency/Service Provider sending referral

Name:

Position:

Organisation:

Phone:

Fax:

Email address:

Address:

Priority

This referral is:

Low

hold over during peak demand

Routine

attend in date order (this may include the consumer being placed on a waiting list)

Urgent

cannot wait

Renewal (ACAS)

For ACAS Assessment

List of Attachments: (please tick relevant box(es))

Consumer Information (required)

Need for Assistance

Health Conditions Profile

Family and Social Network Profile

Other: _____

Summary and Referral (required)

Living and Caring Arrangements Profile

Psychosocial Profile

Care Coordination Plan

Consumer Consent

Health Behaviours Profile

Functional Assessment Summary

Palliative Care Supplement

Other notes:

Referral Acknowledgement

Please be advised that the above referral has been received and: (Please tick appropriate box)

The referral is accepted. Estimated date of consumer assessment dd/mm/yyyy / /

or

The referral is not proceeding for the following reason(s):

Consumer (or consumer's representative) declining

Waiting list time inappropriate for consumer

Ineligible for services

Inappropriate referral

Other

Comments and any further actions undertaken:

Date Acknowledged: dd/mm/yyyy / /

Name:

Position:

Part B: Carer Referral Form

If question is irrelevant or information not known, write Not Applicable or NA

Definition: A carer provides unpaid care and assistance to a person with frailty, disability, chronic illness or mental illness

Record Agency Assigned Consumer Identifier (initial contact agency) or affix label here

Complete this form where a client has an identified primary carer who is experiencing stress, financial, emotional or lifestyle pressures as a result of their caring role. This form should be used for referral to local carer support service. Please phone 1800 059 059 to locate the carer's local Commonwealth Carer Respite Centre or other carer service.

Carer details:

Family Name:		Referral Completion Checklist: <input type="checkbox"/> Yes <input type="checkbox"/> No This Page <input type="checkbox"/> Yes <input type="checkbox"/> No Carer Information <input type="checkbox"/> Yes <input type="checkbox"/> No Consumer Information <input type="checkbox"/> Yes <input type="checkbox"/> No Summary and Referral <input type="checkbox"/> Yes <input type="checkbox"/> No Carer/Consumer Consent Other, specify
Given Names:		
Preferred Name/s:		
Address:		
P/code:		Carer's GP:
Ph: (H):	(W):	Ph:
Consent to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mob.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Care Recipient:
Date of birth: dd / mm / yyyy		

Cares for:

Name:	This page completed on: / / By: <input type="checkbox"/> The carer <input type="checkbox"/> The agency (face-to-face with carer) <input type="checkbox"/> The agency (other, incl. telephone contact with carer) Consumer privacy information brochure provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: Agency:
Address:	
P/code:	
Phone:	
Co-resident carer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessments: (please tick) ACAS <input type="checkbox"/> Level : High/Low Exp. HACC <input type="checkbox"/> DHS <input type="checkbox"/> Other <input type="checkbox"/>	

Impact on Caring:

Carer's emotional health:		
Carer's physical health:		
Carer wellbeing (level of burden/stress):		
Financial issues impacting on caring:		
Current services involved:		
Does consumer have a case manager/case co-ordinator?	<input type="checkbox"/> Yes specify:	<input type="checkbox"/> No

Carer Issues – Reason for Referral: .	Carer Recipient Diagnosis:
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Carer Information

If question is irrelevant or information not known, write Not Applicable or NA

Definition: A carer provides unpaid care and assistance to a person
With frailty, disability, chronic illness or mental illness

Record Agency Assigned Consumer Identifier (initial contact agency)
or affix label here

Source of Referral

Record:

- (1) Self.
- (2) Family, significant other, friend.
- (3) GP / medical practitioner – community based.
- (4) Specialist aged or disability assess team/service (eg. ACAT).
- (5) Comprehensive HACC assessment authority.
- (6) Community nursing service.
- (7) Hospital (public).
- (8) Psychiatric / mental health service or facility.
- (9) Extended care / rehabilitation facility.
- (10) Palliative care facility / hospice.
- (11) Government residential aged care facility.
- (12) Aboriginal health service.
- (13) Carelink centre.
- (14) Other community-based government medical / health service.
- (15) Other government medical / health service.
- (16) Other government community-based services agency.
- (17) Hospital (private).
- (18) Non-government residential aged care facility.
- (19) Other non-government medical / health service.
- (20) Other non-government community-based service.
- (21) Law enforcement agency.
- (22) Other.

Country of Birth

Record: (1) Australia (2) Other
If other, specify:

Indigenous Status

Record:

- (1) Aboriginal but not Torres Strait Islander Origin.
- (2) Torres Strait Islander but not Aboriginal Origin.
- (3) Both Aboriginal and Torres Strait Islander Origin.
- (4) Neither Aboriginal nor Torres Strait Islander Origin.

Date Caring Role Commenced

dd / mm / yyyy or years spent caring

Carer Need

High
Moderate
Low

Primary Care Needs

Record:

- (1) Specific primary health care needs.
- (2) Acute health care needs.
- (3) Palliative Care needs.
- (4) Rehabilitation needs.
- (5) Needs for ongoing management of chronic condition.
- (6) Extended (long-stay in special purpose facility) health care needs.
- (7) Psychogeriatric care needs.
- (8) Geriatric Evaluation and management needs.
- (9) Maintenance care needs.
- (10) Other and unspecified needs.
- (11) Not stated / inadequately described.

Time spent caring per week

Record:

- (1) Less than 20 hours
- (2) 20 - 39 hours
- (3) More than 39 hours

Employment Status

Record:

- (1) Casual
- (2) Full time
- (3) Part time
- (4) Seasonal
- (5) Not in paid employment

Main Language Spoken at Home

Record:

- (1) English
 - (2) Other
- If other, specify:

Interpreter Required

Record:

- (1) Interpreter not needed
- (2) Interpreter needed

Preferred Language

(if not spoken English) including sign language, & any required communication devices or special interpreter needs.

Government Pensioner/ Benefit Status

Record:

- (1) Aged Pension
- (2) Veterans' Affairs Pension
- (3) Disability Support Pension
- (4) Carer Payment (pension)
- (5) Unemployment related benefits
- (6) Other gov. pension or benefit
- (7) No gov. pension or benefit

Card Number:

DVA Card Status

Record:

- (1) No DVA Card
- (2) Yes - Gold Card
- (3) Yes - White Card
- (4) Yes - Other DVA Card

DVA Card Number:

Insurance Status

Insurer Name and Card Number:

Medicare Number:

Health Care Card Number:

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Name: _____

Date of Birth: dd/mm/yyyy / /

Sex: _____

UR Number: _____

or affix label here

Consumer Details

Family Name: _____

Given Names: _____

Preferred Name/s: _____

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? _____

Code: Sex: _____ Code: Title: _____

Home Address

Post code: _____

Postal Address (if different from above)

Post code: _____

Contact phone number/s

(tick preferred number)

Can leave message?

 Home: () Yes No Work: () Yes No Mobile: Yes No Email: Yes NoCountry of Birth: _____ Code: Indigenous Status: _____ Code: Need for Interpreter Services: _____ Code: Preferred Language: _____ Code: Communication Method: _____ Code:

General Practitioner

GP Name: _____

Practice Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name:

Contact Address _____

Post code: _____

Phone numbers

Home: _____

Work: _____

Mobile: _____

Relationship to Consumer: _____

Code:

Is this person the consumer's carer? _____

Code:

Is this person the person who makes the consumer's legal decisions? _____

Code:

Person 2 Name:

Contact Address _____

Post code: _____

Phone numbers

Home: _____

Work: _____

Mobile: _____

Relationship to Consumer: _____

Code:

Is this person the consumer's carer? _____

Code:

Is this person the person who makes the consumer's legal decisions? _____

Code:

Legal Orders:

Code:

Government Pension/Benefit Status:

Code:

Health Care Card Holder Status:

Code:

Card number: _____

Medicare Card:

Card number: _____

Health Insurance Status:

Insurer name: _____

Card number: _____

DVA Card Entitlement:

DVA card type: _____

Code:

DVA card number: _____

Compensables Funding Source:

Code:

Comments:

Name:	Position/Agency:
Sign:	Date: dd/mm/yyyy / / Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues, [provide information to indicate eligibility](#), and an initial action plan when making a referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Summary and Referral Information

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of issues as identified by the Initial Needs Identification (INI)

Current presentation/episode; presenting problem(s) – observed or described features; screening evidence:

Significant Histories/Recent and past history (medical, [developmental](#), functional/daily living skills, social, emotional etc.):

Medications:

Other:

Alerts

Allergies:

Risks: (see code sets) Code:

Additional comments including urgency:

This information collected by:		SRI Page 1 of 2
Name:	Position/Agency:	
Sign:	Date: dd/mm/yyyy / /	Contact number:

Sign:

Date: dd/mm/yyyy / /

Contact number: