

IN-HOME COMMUNITY CARE – REFERRAL FORM

REFERRAL DETAILS

Date of Referral			
Referral Source	<input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> GP <input type="checkbox"/> Hospital <input type="checkbox"/> Aged Care Assessment <input type="checkbox"/> Other		
Referrer Name			
Organisation			
Phone		Email	

CLIENT DETAILS

Client Full Name			
Preferred Name		Date of Birth	
Gender (optional)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Disclosed		
Address			
Phone		Email	
Primary Language		Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have capacity to make decisions about their care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		

CONTACT / REPRESENTATIVE

Name	
Relationship	
Phone	
Representative/Substitute Decision Maker	<input type="checkbox"/> Enduring Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Next of Kin <input type="checkbox"/> Nominated Support Person
Email	
Secondary Contact Name	
Secondary Contact Relationship	
Secondary Contact Phone	
Secondary Contact Email	

REFERRING PRACTITIONER DETAILS

Name			
Clinic Name			
Phone		Email	
Type	<input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> Other		

REASON FOR REFERRAL

Reason for Referral	<input type="checkbox"/> New service <input type="checkbox"/> Change in Care Needs <input type="checkbox"/> Hospital Discharge <input type="checkbox"/> Safety Concerns <input type="checkbox"/> Carer stress
Urgency	<input type="checkbox"/> Urgent (24–48 hrs) <input type="checkbox"/> Priority <input type="checkbox"/> Routine

FUNDING & ELIGIBILITY

Funding Type	<input type="checkbox"/> HCP <input type="checkbox"/> CHSP <input type="checkbox"/> SAH <input type="checkbox"/> NDIS <input type="checkbox"/> DVA <input type="checkbox"/> INSURANCE <input type="checkbox"/> PRIVATE
Package Level	
NDIS/DVA Number/MAC ID	
Current Provider	

REQUESTED SERVICES

Nursing Care	<input type="checkbox"/>	Personal Care	<input type="checkbox"/>	Transport	<input type="checkbox"/>
Allied Health	<input type="checkbox"/>	<input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other _____			

CLINICAL & HOME ENVIRONMENT INFORMATION

Please provide any current medical conditions and recent diagnoses	
Cognitive Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility Status	<input type="checkbox"/> Independent <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Assistance Required
Continence Support Required	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Medication Support Required	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Wound Care Support Required	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Falls in the last 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Behavioural Risks	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Lives Alone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pets in Home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Access Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Please attach relevant clinical information, discharge summary, medication list, or care plan if available</i>	

SERVICE PREFERENCES

Service Start Date	
Preferred Days	<input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun
Preferred Times	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
Worker Preferences	<input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Cultural <input type="checkbox"/> None

CONSENT & PRIVACY

Consent Provided	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client consent to sharing relevant information with medical professionals or emergency services if required	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client / Representative Name	
Signature	
Date	

INTERNAL INTAKE (OFFICE USE ONLY)

Date Received	
Priority Level	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Intake Officer	
Initial Assessment Date	