Referral Form

Date of Referral:	
Date of Appointment:	
Full Name of Client	
Date of Birth	
Address	
Postal address	
Telephone No	
Email Address	
Marital Status	Single ◯ Married ◯ Widowed ◯ Other ◯
Is the client of Aboriginal or Torres Strait Islander decent?	**Y** ◯ **N** ◯ If yes, would the client prefer to be linked in with an ATSI specific agency? **Y** ◯ **N** ◯
Language Spoken	English ☐ Other:
Interpreter Req.	**Y** ◯ **N** ◯

Next of Kin – Emergency contact	
Relationship	
Address	
Email Address	
Contact Number	

Billing/Funding	
NDIS No.	
NDIS Contact Name	
NDIS Item No.	
NDIS Rate	
Name	
Address	
Email Address	
Contact Number	

Other Contact / Case Manager	
Organisation	
Address	
Email Address	
Contact Number	

Referrer	
Relationship	
Address	
Email Address	
Contact Number	

Information about the client (interests, likes, dislikes):
……
……
……

Formal Diagnosis, Medical Information, Allergy Alerts:
……
……
……

Living situation:

◯ Own home / living alone	◯ Own home / with family member or others	◯ Residential Care/Nursing home/SRS/ CRU etc.	◯ Other

Comments: (i.e. pets) ……

Cognition:

◯ Very good	◯ Good	◯ Fair	◯ Poor

Comments……

Communication:

◯ Verbal	◯ Non Verbal	◯ Aids	◯ Other

Comments……

Mobility:

Independent ☐	Assist ☐	Walking Stick ☐	Walking frame ☐
Manual Hoist ☐	Shower Chair ☐	Wheelchair ☐	L frame ☐
Ceiling Hoist ☐	Other:		

Personal Care:

	No Support required	Verbal Prompt	Physical assistance
Shower / Bathing	☐	☐	☐
Toileting	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐

Comments……

Behaviours (Does the client have a BSP – Y ◯ or N ◯ ?
If so, please attach):

……
……

Food preferences/ dietary requirements
……
……

Goals
……
……
……
……

Shift commencement date and time:
……
……
……

Limits:
Maximum hours: ……
Maximum charges: ……
Maximum Kilometers: ……

Shift Routine:
……
……
……

Carer Preference:
(e.g.male/female)……
……

Carer Skills required:

☐ Medication	☐ Bowel care	☐ Epilepsy	☐ Behaviour experience
☐ Peg Feeding	☐ Catheter	☐ Diabetes	☐ Car for transport
☐ Hoist	☐ Condom drainage	☐ Dementia	☐ Full Licence

Other Relevant Information:
……
……

Please complete this referral form and forward, attention to Client Services:
Email enquiries@carechoice.net.au or Fax 1300 737 943.