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……

Does the client have a Behaviour Support Plan or Behaviour Support Plan? Yes ☐ No ☐
If yes then please attach a copy of the plan
……
……

Does the client exhibit behaviours of concern that needs to be managed? Yes ☐ No ☐
If yes, then please list relevant behaviours. This helps ensure that we are appropriately supporting the client.

☐ Social Isolation
☐ Aggressive language and tone
☐ Hurting themselves
☐ Breaking things
☐ Disruptive behaviour
☐ Sexualised behaviours of concern
☐ Emotional outbursts
☐ Evidence of substance abuse
☐ Physical aggression/violence
☐ Intimidation or harassment
☐ Unwanted touching

☐ Any other behaviours of concern or challenging behaviours, then please list:

……
……

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.

Version Control

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Version: 9	**Effective date:** 2 March 2020
Next review date: 1 March 2021	