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	**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):

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Formal Diagnosis, Medical Information, Allergy Alerts:

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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 If so, please attach): ◯ or N ◯ ?

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Food preferences/ dietary requirements

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Goals

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Shift commencement date and time:

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Limits:

Maximum hours: .....
Maximum charges: .....
Maximum Kilometers: .....

Shift Routine:

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.....
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Carer Preference:

(e.g.male/female).....
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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:

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Please send completed form to
enquiries@carechoice.com.au or fax 1300 737 943