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):

……

……

……

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 If so, please attach): ◯ or N ◯ ?

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.....

Food preferences/ dietary requirements

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.....

Goals

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.....
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.....

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:

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

CareChoice
Taking care further