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| **Carer Referral Form** | A carer provides unpaid care and assistance to a person who is frail aged, has dementia, a disability, a mental illness or receives palliative care |



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| **For all carer enquiries including aged, mental health, disability or young carers please call 1800 052 222.** **Please call 9495 2500 if calling from a mobile phone or out of region.** |

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| **Carer details** |

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| **Family Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Given Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P/code \_\_\_\_\_\_\_\_\_\_ |
| **Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Date of birth** (dd/mm/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Relationship status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Employment status** 🞏 Casual 🞏 Full time 🞏 Part time 🞏 Seasonal 🞏 Not in paid employment |
| **Relationship to Care Recipient** (CR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Co-resident Carer** 🞏 Yes 🞏 No |
| **Date caring role commenced** / / or \_\_\_\_\_ (years) |
| **Carer need** 🞏 High 🞏 Moderate 🞏 Low |
| **Carer role** 🞏 Primary 🞏 Other  🞏 Not stated (inadequately described) |
| **Time spent caring per week**🞏Less than 20 hours 🞏20-39 hours 🞏More than 39 hours |
| **Current Formal Services received by Carer**🞏 Is not receiving services🞏 Is receiving a package🞏 Is receiving one or more formal services🞏 Not stated (inadequately described) |

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| **Informal Supports**🞏 Father 🞏 Male partner 🞏Other relative–male 🞏 Mother 🞏 Female partner 🞏Other relative–female🞏Daughter 🞏 Daughter-in-law 🞏Friend/neighbour– female🞏 Son 🞏 Son-in-law 🞏 Friend/neighbour – male🞏 No informal support 🞏 Not stated (inadequately described) |
| **Country of birth** 🞏 Australia 🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Language spoken at home** 🞏 English 🞏 Other (specify)­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Interpreter required** 🞏 Yes 🞏 No |
| **Preferred language** **(if not spoken English)** including sign language and any required communication devices or special interpreter needs (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ |
| **Indigenous Status** 🞏 Aboriginal but not Torres Strait Islander origin🞏 Torres Strait Islander but not Aboriginal origin🞏 Both Aboriginal and Torres Strait Islander origin🞏 Neither Aboriginal nor Torres Strait Islander origin |
| **Government Pensioner / Benefit Status**🞏 Aged Pension 🞏 Veterans Affairs Pension🞏 Disability Support Pension 🞏 Carer payment (pension)🞏 No gov. pension or benefit 🞏 Carer allowance🞏Unemployment benefits 🞏Other gov. pension or benefit |
| **DVA Card Status** 🞏 No DVA card 🞏 Yes (Gold) 🞏 Yes (White) 🞏 Yes (Other) |

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| **Care Recipient (CR), i.e. person being cared for** |

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| **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Does the CR have a case manager/case coordinator**🞏Yes🞏No If yes, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) \_\_\_\_\_\_\_\_\_\_\_\_\_ (phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(agency) |
| **Assessments** 🞏ACAS 🞏High 🞏Low 🞏HACC 🞏DHS 🞏Other |
| **Care Recipient Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Current Formal Services received by Care Recipient**🞏 Is not receiving services 🞏 Is receiving one or more formal services🞏 Is using a package🞏 Not stated (inadequately described) |

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| **Primary Care Needs**🞏 Specific primary health care needs🞏 Acute health care needs🞏 Palliative care needs🞏 Rehabilitation needs🞏 Needs for ongoing management of chronic condition🞏 Extended (long-stay in special purpose facility) health care needs🞏 Psychogeriatric care needs🞏 Geriatric evaluation and management needs🞏 Maintenance care needs🞏 Other and unspecified needs🞏 Not stated (inadequately described) |

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| **Referral Information** |

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| **Referral Completion Checklist**Carer information 🞏 YesConsumer information 🞏 YesSummary and Referral 🞏 YesCarer / CR Consent 🞏 YesFunctional Assessment 🞏 YesOther (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_­­­­­\_\_\_\_\_\_\_\_\_ | **Reason for Referral** (please provide more information in Summary and Referral) |