Referral Form- Home Care

CLIENT'S DETAILS	
First Name	
Surname	
Aged Care Client Number	
Referral Code	
Have You Had Financial Assessment by Assessment Team?	☐ Yes ☐ No
Do You Have Your Approval Letter?	☐ Yes ☐ No
Are You From Aboriginal or Torres Strait Islander Descent?	☐ Yes ☐ No
Date of Birth	-------/------/------
Address	
Home Phone Number	
Mobile Number	
Gender	☐ Male ☐ Female
Next of Kin Name	
Next of Kin Phone Number	
Brief Medical History (if any):	
List of Medications (if any):	
GP's Name	
GP's Phone Number	
Mobility Status	☐ Independent ☐ Assist by One ☐ Assist by two ☐ Using Frame ☐ Using Wheel Chair ☐ Bed Bound

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Sensory Impairment (if any):	
Psychological /special needs (if any)	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ De facto ☐ Widowed
Living Condition	☐ Living alone ☐ Living with partner ☐ Living with family member ☐ Living in group home
Working Status	☐ On Pension ☐ Do not work ☐ Working ☐ Do Volunteer Work

DETAILS OF PERSON OR ORGANISATION MAKING THIS REFERRAL	
Date of Referral	----/----/----
First Name	
Surname	
Name of Organisation	
Contact Number	
Email	
Your Relationship to Client	

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TYPE OF CARE PACKAGES

- ☐ Home Care Level 1
- ☐ Home Care Level 2
- ☐ Home Care Level 3
- ☐ Home Care Level 4
- ☐ HACC
- ☐ DVA
- ☐ Private Care (No Package)
- ☐ Other (Please specify): ……

TYPE OF SERVICES REQUIRED

- ☐ Personal Care & Hygiene
- ☐ Home Services (cleaning, gardening & food preparation)
- ☐ Medication Administration
- ☐ Nurse Escort for Appointments
- ☐ Respite Care
- ☐ Palliative Care
- ☐ Dementia & Alzheimer Care
- ☐ Disability care
- ☐ Rehabilitation & Injury management
- ☐ Post Hospital Care
- ☐ Social Break & companionship
- ☐ Private Care
- ☐ Therapeutic Care

SUGGESTION FOR CARE SCHEDULE

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM 0600-1800							
PM 1800-2200							
ND 2200-0600							
Sleepover							

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GENERAL INFORMATION	
Are you currently receiving any services?	☐ Yes (Please specify): ☐ No
What gender care worker would you prefer to have?	☐ Male nurse ☐ Female nurse ☐ Either, does not matter
Do you have any preference for nursing staff with specific cultural background or language skills (in case of non English speaking clients)?	☐ Yes (Please specify) ☐ No
What date would you like our service to commence?	-----/-----/-----
What date would you like our service to end?	-----/-----/-----
Do you need staff to stay overnight?	☐ Yes ☐ No ☐ Sometimes
Do you require transport to be provided as part of your care?	❑ Yes ❑ No
Additional Comment:	