REFERRAL FORM – INSURANCE CLIENT

CLIENT INFORMATION

Field	Response
First Name	
Surname	
Claim Number (if applicable)	
Insurance Company	
Approval Letter Issued? (attach copy)	☐ Yes ☐ No
Aboriginal or Torres Strait Islander Descent	☐ Yes ☐ No
Date of Birth	____ / ____ / ____
Address	
Home Phone	
Mobile Phone	
Gender	☐ Male ☐ Female ☐ Other
Next of Kin Name	
Next of Kin Phone	

MEDICAL & SUPPORT DETAILS

Field	Response
Brief Medical History	
Medications	
GP's Name	
GP's Phone Number	

MOBILITY STATUS (TICK ALL THAT APPLY)

☐ Independent
☐ Needs assistance from one
☐ Needs assistance from two
☐ Uses walking frame

☐ Uses wheelchair ☐ Bed bound

VISUAL, NEURODIVERSITY & SPECIAL NEEDS IMPAIRMENTS

Impairment Type	☐ Select if applicable
NIL	☐
Visual impairment	☐
Hearing impairment	☐
Sensory processing issues	☐
Autism spectrum disorder (ASD)	☐
Psychological / Special Needs	☐
Other (please specify): _____	☐

PERSONAL INFORMATION

Field	Response
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ De facto ☐ Widowed ☐ Separated
Living Arrangements	☐ Living alone ☐ With partner ☐ With family ☐ Group home
Employment Status	☐ Pensioner ☐ Not working ☐ Employed ☐ Volunteer

REFERRER DETAILS

Field	Response
Date of Referral	____ / ____ / ____
Referrer First Name	
Referrer Surname	
Organisation Name	
Contact Number	
Email	
Relationship to Client	

Account Responsible	
Billing Contact (Email & Phone)	

FUNDING CATEGORY

Funding Type	☐ Select if applicable
Insurance Client	☐
Private Client (no package)	☐
Support at Home Program	☐
NDIS (National Disability Insurance Scheme)	☐
DVA (Department of Veterans' Affairs)	☐
Other (please specify): _____	☐

CARE SERVICES REQUIRED

Service Type	☐ Select if required
Personal Care & Hygiene	☐
Home Services	☐
Medication Administration	☐
Nurse Escort	☐
Respite Care	☐
Palliative Care	☐
Dementia Care	☐
Disability Care	☐
Rehab & Injury Management	☐
Post-Hospital Care	☐
Wound Dressing	☐
Companionship	☐
Private Care	☐
Therapeutic Care	☐

CARE SCHEDULE PREFERENCES

Time Slot	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning (AM)	☐	☐	☐	☐	☐	☐	☐
Afternoon (PM)	☐	☐	☐	☐	☐	☐	☐
Night (ND)	☐	☐	☐	☐	☐	☐	☐
Overnight (Non-Active)	☐	☐	☐	☐	☐	☐	☐
Overnight (Active)	☐	☐	☐	☐	☐	☐	☐

ADDITIONAL INFORMATION

Question	Response
Receiving other services?	☐ Yes (specify): _____ ☐ No
Preferred Care Worker Gender	☐ Male ☐ Female ☐ No Preference
Cultural/Language Preferences	☐ Yes (specify): _____ ☐ No
Service Start Date	____ / ____ / ____
Service End Date	____ / ____ / ____
Need overnight staff?	☐ Yes ☐ No ☐ Sometimes
Require transport?	☐ Yes ☐ No
Additional Comments	....