

Referral Form

For all intents and purposes, 'the client' refers to the person being referred to Dependable Care.

Please email completed form to melissa@dependablecare.net.au

PART A: Referrer's Details	
Full name:	
I am:	<input type="checkbox"/> Known personally to the client <input type="checkbox"/> Known professionally to the client
Relationship to the client:	
If known professionally to the client, please note:	
Agency or organisation:	
Position:	
Phone:	
Email:	
Reason for referral:	
Which Dependable Care location/s are you interested in referring the client to?	<input type="checkbox"/> Murray Lodge (Wilston, QLD) <input type="checkbox"/> Bamfield Lodge (Heidelberg Heights, VIC) <input type="checkbox"/> Reservoir Lodge (Reservoir, VIC) <input type="checkbox"/> Rooming House (QLD) <input type="checkbox"/> Rooming House (VIC)

PART B: Client's Details	
First name:	
Last name:	
Date of Birth:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (please specify): _____
Language primarily used:	
Where does the client currently reside?	<input type="checkbox"/> Another Supported Residential Service (SRS)/Level 3 Accommodation <input type="checkbox"/> Own residence <input type="checkbox"/> With family <input type="checkbox"/> With friends <input type="checkbox"/> Homeless/shelter <input type="checkbox"/> Other (please specify): _____
If the client currently resides at another Supported Residential Service (SRS)/Level 3 Accommodation, please note:	
Name of current Supported Residential Service (SRS)/Level 3 Accommodation:	
Type of income received:	<input type="checkbox"/> Centrelink <input type="checkbox"/> Veterans' Affairs <input type="checkbox"/> Overseas Pension <input type="checkbox"/> Other (please specify): _____
If the client receives Centrelink, Veterans' Affairs or Overseas Pension, please note:	

Customer Reference Number (CRN) or Department of Veterans' Affairs (DVA) number:			
Does the client have a legal guardian? <i>(If yes, you are responsible for contacting them regarding this referral)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full name:	
		Phone:	
		Email:	
Does the client have an administrator? <i>(If yes, you are responsible for contacting them regarding this referral)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full name:	
		Phone:	
		Email:	
		Client Reference Number:	
Does the client have a Power of Attorney (POA)? <i>(If yes, you are responsible for contacting them regarding this referral)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full name:	
		Phone:	
		Email:	
Next of Kin Details	Full name:		
	Relationship to the client:		
	Phone:		
	Email:		

Medical Practitioner Details	Full name:	
	Address:	
	Phone:	
	Email:	

Health & Medical	
Does the client have medication/s with them?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please specify): _____
Is the client able to administer their own medication/s?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please specify): _____
Please list any medication/s the client requires: <i>(Please specify drug name, dose, frequency, duration and when it was last taken)</i>	
Pharmacy used: <i>(e.g. Chemist Warehouse, ScriptRITE etc.)</i>	
Physical status: <i>(Please list any pre-existing medical conditions or allergies)</i>	

<p>Cognitive status: <i>(Please list any cognitive impairment/s to which staff need to be alerted e.g. memory impairment etc.)</i></p>	
<p>The client is registered with:</p>	<p><input type="checkbox"/> National Disability Insurance Scheme (NDIS) <input type="checkbox"/> Transport Accident Commission (TAC) <input type="checkbox"/> WorkSafe <input type="checkbox"/> Aged Care <input type="checkbox"/> Department of Veterans' Affairs (DVA) <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____</p>
<p align="center">If the client is registered with the National Disability Insurance Scheme (NDIS), Transport Accident Commission (TAC), WorkSafe, Aged Care or Department of Veterans' Affairs (DVA), please note:</p>	
<p>Support coordinator or case manager's full name:</p>	
<p>Support coordinator or case manager's phone:</p>	
<p>Support coordinator or case manager's email:</p>	
<p>Disability: <i>(Please list any disabilities known, including any undiagnosed)</i></p>	
<p>Mental health status: <i>(Please specify any mental health concerns to which staff need to be alerted)</i></p>	

<p>The client is subject to:</p>	<p><input type="checkbox"/> Involuntary Community Treatment Order (ICTO) <input type="checkbox"/> Court-Ordered Treatment Order <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____</p>
<p align="center">If the client is subject to an Involuntary Community Treatment Order (ICTO) or a Court-Ordered Treatment Order, please note:</p>	
<p>Case manager's full name:</p>	
<p>Case manager's phone:</p>	
<p>Case manager's email:</p>	
<p>Please select any behaviour/s the client displays that may require special consideration:</p>	<p><input type="checkbox"/> Self-harm <input type="checkbox"/> Physical aggression <input type="checkbox"/> Verbal aggression <input type="checkbox"/> Absconding <input type="checkbox"/> Smoking <input type="checkbox"/> Drug use <input type="checkbox"/> Alcohol use <input type="checkbox"/> Self-motivation <input type="checkbox"/> Impulse control <input type="checkbox"/> Capacity to share <input type="checkbox"/> Capacity for cooperation <input type="checkbox"/> Capacity to socialise <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____</p>
<p>Additional comments regarding behaviour/s that may require special consideration: <i>(Please provide further detail where possible and detail any known triggers)</i></p>	

<p>Please select any aids the client requires:</p>	<p><input type="checkbox"/> Walking stick</p> <p><input type="checkbox"/> Walking frame</p> <p><input type="checkbox"/> Four-wheel walker</p> <p><input type="checkbox"/> Wheelchair</p> <p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Hearing aid</p> <p><input type="checkbox"/> Interpreter</p> <p><input type="checkbox"/> Dentures</p> <p><input type="checkbox"/> Continence aids</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Other (please specify): _____</p>
<p>Please select any personal care tasks that may require prompting, supervision or active assistance:</p>	<p><input type="checkbox"/> Eating/drinking/diet</p> <p><input type="checkbox"/> Showering/bathing</p> <p><input type="checkbox"/> Dressing</p> <p><input type="checkbox"/> Toileting</p> <p><input type="checkbox"/> Laundry</p> <p><input type="checkbox"/> Mobility</p> <p><input type="checkbox"/> Shaving/grooming</p> <p><input type="checkbox"/> Dental hygiene</p> <p><input type="checkbox"/> Foot care/nail care</p> <p><input type="checkbox"/> Housekeeping</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Other (please specify): _____</p>
<p>Additional comments regarding personal care tasks:</p> <p><i>(Please detail level of assistance required for the selected personal care task/s)</i></p>	

Community Living & Recreation	
Is this client able to keep appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please specify): _____
Please list any community based social activities the client attends:	
Please list any special interests or hobbies the client has:	
Does the client currently access any other services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the client currently accesses any other services, please provide details:	
Details of other services:	
Has the client been referred to any other additional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the client has been referred to any other additional services, please provide details:	
Details of other services:	

Additional Information	
Please provide any other relevant information:	

PART C: Acknowledgement & Agreement	
<p><i>As the referrer, you must seek permission and agreement to our Residential Service Agreement (RSA) from any relevant legal guardian or administrator before the client can reside in a Dependable Care facility.</i></p> <p style="text-align: center;"><input type="checkbox"/> I agree</p>	
<p><i>By completing this form, you confirm that the information provided is accurate. Any false or misleading information may result in liability – either personally or on behalf of the service provider you represent – for any damages or financial losses incurred by the client.</i></p> <p style="text-align: center;"><input type="checkbox"/> I agree</p>	
Referrer's full name:	
Referrer's signature:	
Date signed:	