

Referral Form

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

Please email completed form to info@dependablecaredrps.com.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:	

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:	
Which state is the client based in?	<input type="checkbox"/> Queensland <input type="checkbox"/> Victoria <input type="checkbox"/> Tasmania
Where does the client currently reside?	<input type="checkbox"/> A Supported Independent Living (SIL)/Individualised Living Option (ILO)/Medium-Term Accommodation (MTA)/Short-Term Respite (STR) accommodation <input type="checkbox"/> A 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 in a Supported Independent Living (SIL)/Individualised Living Option (ILO)/Medium-Term Accommodation (MTA)/Short-Term Respite (STR) accommodation, please note:	
Name of the company providing the current SIL/ILO/MTA/STR accommodation:	
If the client currently resides at a Supported Residential Service (SRS)/Level 3 Accommodation, please note:	
Name of Supported Residential Service (SRS)/Level 3 Accommodation:	

Next of Kin Details	Full name:		
	Relationship to the client:		
	Phone:		
	Email:		
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:	
Does the client have a nominee? <i>(If yes, you are responsible for contacting them)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full name:	
		Phone:	

<i>regarding this referral)</i>		Email:	
The client is registered with:	<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): _____		
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:			
Support coordinator or case manager's full name:			
Support coordinator or case manager's phone:			
Support coordinator or case manager's email:			
If the client is registered with National Disability Insurance Scheme (NDIS), please note:			
NDIS number:			
NDIS plan dates	Start:		
	End:		
NDIS goals:			

Is the funding agency managed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the funding self-managed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the funding plan managed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Full name:	
		Phone:	
		Email:	

Health & Medical		
Medical Practitioner Details	Full name:	
	Address:	
	Phone:	
	Email:	
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>		

<p>Physical status: <i>(Please list any pre-existing medical conditions, management plans or allergies)</i></p>	
<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>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>Please select any aid/s the client requires:</p>	<p> <input type="checkbox"/> Walking stick <input type="checkbox"/> Walking frame <input type="checkbox"/> Four-wheel walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing aid <input type="checkbox"/> Interpreter <input type="checkbox"/> Dentures <input type="checkbox"/> Continence aids <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____ </p>

Behaviour	
Does the client currently have a Behaviour Support Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please specify): _____
The client is subject to:	<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): _____
If the client is subject to an Involuntary Community Treatment Order (ICTO) or a Court-Ordered Treatment Order, please note:	
Case manager's full name:	
Case manager's phone:	
Case manager's email:	
Please select any behaviour/s the client displays that may require special consideration:	<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>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 personal care tasks that may require prompting, supervision or active assistance:</p>	<p><input type="checkbox"/> Eating/drinking/diet <input type="checkbox"/> Showering/bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Laundry <input type="checkbox"/> Mobility <input type="checkbox"/> Shaving/grooming <input type="checkbox"/> Dental hygiene <input type="checkbox"/> Foot care/nail care <input type="checkbox"/> Housekeeping <input type="checkbox"/> None <input type="checkbox"/> Other (please specify): _____</p>
<p>Additional comments regarding personal care tasks: <i>(Please detail level of assistance required for the selected personal care task/s)</i></p>	

Community Living & Recreation	
<p>Is the client able to keep appointments?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please specify): _____</p>
<p>Please list any community based social activities the client attends:</p>	

<p>Please list any special interests or hobbies the client has:</p>	
<p>Please list any likes the client has:</p>	
<p>Please list any dislikes the client has:</p>	

PART C: Support/s	
<p>Please select the support service/s you are seeking for the client:</p>	<p> <input type="checkbox"/> Housing Support <input type="checkbox"/> Positive Behaviour Support <input type="checkbox"/> Nursing <input type="checkbox"/> Support Coordination <input type="checkbox"/> Psychosocial Recovery Coaching <input type="checkbox"/> Plan Management <input type="checkbox"/> Core Support <input type="checkbox"/> Consumables </p>
<p>Please note the support budget/s for the support service/s you are seeking for the client:</p>	
<p>Please list any support service preferences the client has: <i>(e.g. Female only etc.)</i></p>	
<p>Does the client currently access any other services?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>
<p>If the client currently accesses any other services, please provide details:</p>	

Details of other services the client currently accesses:	
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Additional Information	
Please provide any other relevant information:	

PART D: Acknowledgement & Agreement	
<p><i>As the referrer, you must seek permission and agreement to our Service Agreement from any relevant legal guardian or administrator before the client can proceed with any Dependable Care DRPS services.</i></p> <p style="text-align: center;"><input type="checkbox"/> I agree</p>	
<p><i>I understand that Dependable Care DRPS may contact those noted in the referral form regarding this referral.</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:	