PO Box 3191
Mentone East VIC 3194
PH: (03) 9598 4620
FAX: (03) 9598 4360
E: info@acares.com.au

CLIENT REFERRAL FORM

Complete all white areas and relevant shaded areas

Client Name: ______________________________ Date of referral: ___________

Address: ____

Suburb: ________________________ Postcode: ____________ Gender: ☐ M ☐ F

Phone Number: __________________ Mobile: __________________________

Date of Birth: ___________________ Email: ___________________________

Next of Kin: _____________________ Relationship: ______________________

Address: ____

Suburb: _____________________________ Postcode: ____________________

Phone Number: __________________ Mobile: __________________________

Funding Body: ☐ TAC ☐ WorkSafe ☐ DHS ☐ Self-funded ☐ Other: ___________

Date of Accident: _________________ Claim Number: _____________________

Funding Contact:____

Phone Number: __________________ Email: ___________________________

Referrer name: ___________________ Role: ____________________________

Organisation: ____________________ Contact: __________________________

Therapy Contact: _________________ Role: ____________________________

Phone Number: __________________ Email: ___________________________

SERVICE/S REQUESTED:

☐ Permanent Accommodation

Preferred area: ____

Preferences in support workers: _____________________________________

____

Preferences for housemates: ____

____

Current living situation: ____

Accommodation specific needs: *eg King single bed* ______________________

____

Date Dev 13/9/2013
Date Updated 13/9/2013 10:05:25 AM
Authoriser : Jenna Willett
Date Authorised 9/13/2013
Y:\001_ADMIN_ACCREDITATION_STRUCTURE\006_FORMS\CLIENT REFERRAL FORM130312.docx

PO Box 3191
Mentone East VIC 3194
PH: (03) 9598 4620
FAX: (03) 9598 4360
E: info@acares.com.au

CLIENT REFERRAL FORM

☐ Respite

Preferred area: ______________________________

Desired days/dates/frequency: ______________________________

Requirements in support workers: ______________________________

____

Preferences for housemates: ______________________________

Accommodation specific needs: *eg King single bed* ______________________________

____

☐ In Home Attendant Care

Day/s and time required (circle day, write times below):

MON TUES WED THURS FRI SAT SUN

Hours approved (& frequency – eg per week, per month): ______________________________

Requirements in support workers: ______________________________

Activity specifics (eg hydrotherapy): ______________________________

☐ Occupational Therapy

Assessment requested: ______________________________

Hours approved: ______________________________

☐ Community Access Planning

Activities of interest: ______________________________

Goal: ______________________________

____

☐ Holiday Planning

☐ Individualised ☐ Shared Care

Location/s of interest: ______________________________

Proposed timeframe: ______________________________

PO Box 3191
Mentone East VIC 3194
PH: (03) 9598 4620
FAX: (03) 9598 4360
E: info@acares.com.au

CLIENT REFERRAL FORM

☐ Community Group/s

☐ Social Dinners ☐ Go Karting ☐ Music ☐ Community Kitchens
☐ Southern Art ☐ Games ☐ Fishing ☐ Saturday Social
☐ Digital Storytelling ☐ Coffee Club ☐ Mechanics ☐ Other interest: ___________________

☐ Domestic Support

Brief description: ____

CLIENT ABILITIES & SUPPORT

Diagnosis: ____

Mobility: ☐ Ambulant & independent ☐ Ambulant + frame ☐ Ambulant + supervision
☐ Manual wheelchair ☐ Powered wheelchair ☐ Independent ☐ Assistance

Transfers: ☐ Independent ☐ Assisted ☐ Standing hoist ☐ Mobile hoist

Toileting: ☐ Independent ☐ Equipment ☐ Assistance x1 ☐ Assistance x2
↳ Specify: ________________________

Bathing: ☐ Independent ☐ Equipment ☐ Assistance x1 ☐ Assistance x2
↳ Specify: ________________________

Specialised Care Needs: (eg wound care, diabetes, PEG feed, tracheostomy etc)

____

____

____

Social Situation:

____

____

____

Behaviour Support: (eg behaviours of concern, management etc)

____

____

____

Positive Behaviour Support Plan in place = Y / N (if Y, please provide)

PO Box 3191
Mentone East VIC 3194
PH: (03) 9598 4620
FAX: (03) 9598 4360
E: info@acares.com.au

CLIENT REFERRAL FORM

Office use only:

Referral received by: ______________________________ *Date:* _______________

Follow up notes: ____

____

____

____

____