



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* _____



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/intervention requested: _____

Hours approved: _____

Community Access Planning

Activities of interest: _____

Goal: _____

Holiday Planning

Individualised Shared Care

Location/s of interest: _____

Proposed timeframe: _____



CLIENT REFERRAL FORM

Community Group/s

| | | | |
|---|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Social Dinners | <input type="checkbox"/> Go Karting | <input type="checkbox"/> Music | <input type="checkbox"/> Community Kitchens |
| <input type="checkbox"/> Southern Art | <input type="checkbox"/> Games | <input type="checkbox"/> Fishing | <input type="checkbox"/> Saturday Social |
| <input type="checkbox"/> Digital Storytelling | <input type="checkbox"/> Coffee Club | <input type="checkbox"/> Mechanics | <input type="checkbox"/> 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)



**Accommodation
& Care Solutions**
Accommodation, Care, Respite & Planning



**Rehabilitation
Care Solutions**
Helping you move forward

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CLIENT REFERRAL FORM

Office use only:

Referral received by: _____ Date: _____

Follow up notes: _____
