Confidential Referral Cover Sheet

Date Sent: dd/mm/yyyy / /	**Consumer**
Number of Pages (including cover sheet):	Name: Date of Birth: dd/mm/yyyy / / Sex: UR Number: or affix label here

Referral to	Agency/Service Provider sending referral
Name:	Name:
Position:	Position:
Organisation:	Organisation:
Phone:	Phone:
Fax:	Fax:
Email address:	Email address:
Address:	Address:

Priority

This referral is:	☐ Low *hold over during peak demand*	☐ Routine *attend in date order (this may include the consumer being placed on a waiting list)*	☐ Urgent *cannot wait*	☐ Renewal (ACAS) *For ACAS Assessment*

List of Attachments: **(please tick relevant box(es))**

Consumer Information (required)	Summary and Referral (required)	☐ Consumer Consent
☐ Need for Assistance	☐ Living and Caring Arrangements Profile	☐ Health Behaviours Profile
☐ Health Conditions Profile	☐ Psychosocial Profile	☐ Functional Assessment Summary
☐ Family and Social Network Profile	☐ Care Coordination Plan	☐ Palliative Care Supplement
☐ Other: ______		

Other notes:

Referral Acknowledgement

Please be advised that the above referral has been received and: *(Please tick appropriate box)*

☐ **The referral is accepted**. Estimated date of consumer assessment dd/mm/yyyy / /

or

☐ **The referral is not proceeding** for the following reason(s):

☐ Consumer (or consumer's representative) declining	☐ Waiting list time inappropriate for consumer	☐ Ineligible for services	☐ Inappropriate referral	☐ Other
Comments and any further actions undertaken:				
Date Acknowledged: dd/mm/yyyy / /	Name:		Position:	

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Part B: Carer Referral Form

If question is irrelevant or information not known, write Not Applicable or NA

Definition: A carer provides unpaid care and assistance to a person with frailty, disability, chronic illness or mental illness

Record Agency Assigned Consumer Identifier (initial contact agency) or affix label here

Complete this form where a client has an identified primary carer who is experiencing stress, financial, emotional or lifestyle pressures as a result of their caring role. This form should be used for referral to local carer support service. Please phone 1800 059 059 to locate the carer's local Commonwealth Carer Respite Centre or other carer service.

Carer details:

Family Name:		**Referral Completion Checklist:** ☐ Yes ☐ No This Page ☐ Yes ☐ No Carer Information ☐ Yes ☐ No Consumer Information ☐ Yes ☐ No Summary and Referral ☐ Yes ☐ No Carer/Consumer Consent Other, specify
Given Names:		
Preferred Name/s:		
Address:		
P/code:		Carer's GP: Ph: Consent to contact? ☐ Yes ☐ No
Ph: (H):	(W):	
Mob.	Sex ☐ Male ☐ Female	Relationship to Care Recipient:
Date of birth: dd / mm / yyyy		

Cares for:

Name:	**This page completed on:** / / By: ☐ The carer ☐ The agency (face-to-face with carer) ☐ The agency (other, incl. telephone contact with carer) Consumer privacy information brochure provided? ☐Yes ☐No Name: Agency:
Address:	
P/code:	
Phone:	
Co-resident carer: ☐ Yes ☐ No	

Assessments: (please tick) ACAS ☐ Level : High/Low Exp. HACC ☐ DHS ☐ Other ☐

Impact on Caring:

Carer's emotional health:		
Carer's physical health:		
Carer wellbeing (level of burden/stress):		
Financial issues impacting on caring:		
Current services involved:		
Does consumer have a case manager/case co-ordinator?	☐Yes specify:	☐No

Carer Issues – Reason for Referral: .	Carer Recipient Diagnosis:

Carer Information

If question is irrelevant or information not known, write Not Applicable or NA

Definition: A carer provides unpaid care and assistance to a person With frailty, disability, chronic illness or mental illness

Record Agency Assigned Consumer Identifier (initial contact agency) or affix label here

Source of Referral

Record:
(1) Self.
(2) Family, significant other, friend.
(3) GP / medical practitioner – community based.
(4) Specialist aged or disability assess team/service (eg. ACAT).
(5) Comprehensive HACC assessment authority.
(6) Community nursing service.
(7) Hospital (public).
(8) Psychiatric / mental health service or facility.
(9) Extended care / rehabilitation facility.
(10) Palliative care facility / hospice.
(11) Government residential aged care facility.
(12) Aboriginal health service.
(13) Carelink centre.
(14) Other community-based government medical / health service.
(15) Other government medical / health service.
(16) Other government community-based services agency.
(17) Hospital (private).
(18) Non-government residential aged care facility.
(19) Other non-government medical / health service.
(20) Other non-government community-based service.
(21) Law enforcement agency.
(22) Other.

Country of Birth

Record: (1) Australia (2) Other
If other, specify:

Indigenous Status

Record:
(1) Aboriginal but not Torres Strait Islander Origin.
(2) Torres Strait Islander but not Aboriginal Origin.
(3) Both Aboriginal and Torres Strait islander Origin. (4) Neither Aboriginal nor Torres Strait Islander Origin.

Date Caring Role Commenced

dd / mm / yyyy or years spent caring

Carer Need

High
Moderate
Low

Primary Care Needs

Record:
(1) Specific primary health care needs.
(2) Acute health care needs.
(3) Palliative Care needs.
(4) Rehabilitation needs.
(5) Needs for ongoing management of chronic condition.
(6) Extended (long-stay in special purpose facility) health care needs.
(7) Psychogeriatric care needs.
(8) Geriatric Evaluation and management needs.
(9) Maintenance care needs.
(10) Other and unspecified needs.
(11) Not stated / inadequately described.

Time spent caring per week

Record:
(1) Less than 20 hours
(2) 20 - 39 hours
(3) More than 39 hours

Employment Status

Record:
(1) Casual
(2) Full time
(3) Part time
(4) Seasonal
(5) Not in paid employment

Main Language Spoken at Home

Record:
(1) English (2) Other
If other, specify:

Interpreter Required

Record:
(1) Interpreter not needed (2) Interpreter needed

Preferred Language

(if not spoken English) including sign language, & any required communication devices or special interpreter needs.

Government Pensioner/ Benefit Status

Record:
(1) Aged Pension
(2) Veterans' Affairs Pension
(3) Disability Support Pension
(4) Carer Payment (pension)
(5) Unemployment related benefits
(6) Other gov. pension or benefit
(7) No gov. pension or benefit

Card Number:

DVA Card Status

Record:
(1) No DVA Card
(2) Yes - Gold Card
(3) Yes - White Card
(4) Yes - Other DVA Card

DVA Card Number:

Insurance Status

Insurer Name and Card Number:

Medicare Number:

Health Care Card Number:

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Consumer Details

Family Name:

Given Names:

Preferred Name/s:

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? Code:

Sex: **Code:** **Title:**

Home Address

Post code:

Postal Address (if different from above)

Post code:

Contact phone number/s *(tick preferred number)* Can leave message?

- ☐ Home: ( ) ☐ Yes ☐ No
- ☐ Work: ( ) ☐ Yes ☐ No
- ☐ Mobile: ☐ Yes ☐ No
- ☐ Email: ☐ Yes ☐ No

Country of Birth: Code:

Indigenous Status: Code:

Need for Interpreter Services: Code:

Preferred Language: Code:

Communication Method: Code:

General Practitioner

GP Name:

Practice Name:

Address:

Phone:

Fax:

Email:

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name:

Contact Address

Post code:

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: Code:

Is this person the consumer's carer? Code:

Is this person the person who makes the consumer's legal decisions? Code:

Person 2 Name:

Contact Address

Post code:

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: Code:

Is this person the consumer's carer? Code:

Is this person the person who makes the consumer's legal decisions? Code:

Legal Orders: Code:

Government Pension/Benefit Status: Code:

Health Care Card Holder Status: Code:

Card number:

Medicare Card:

Card number:

Health Insurance Status:

Insurer name:

Card number:

DVA Card Entitlement:

DVA card type: Code:

DVA card number:

Compensables Funding Source: Code:

Comments:

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Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues, provide information to indicate eligibility, and an initial action plan when making a referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of issues as identified by the Initial Needs Identification (INI)

Current presentation/episode; presenting problem(s) – observed or described features; screening evidence:

Significant Histories/Recent and past history (medical, developmental, functional/daily living skills, social, emotional etc.):

Medications:

Other:

Alerts

Allergies:

Risks: (see code sets) Code:

Additional comments including urgency:

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Current Services

Record services used in the last twelve months. Consider all health and community services.

Agency	Service Type Code:	Record contact details or other information as appropriate

Referral Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required.

Date Referral/s Sent: dd/mm/yyyy / /

Agency	Service Type Code:	Phone Number	Purpose of Referral	Consumer Consent Code:	Referral Method Code:	Feedback to

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consumer Consent to Share Information

To record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth: dd/mm/yyyy

Sex:

UR Number:

or affix label here

Section 1: Proposed Information Uses and Disclosures

Service Type Examples: – Physiotherapy – Specialist consultant	Name of Agency Examples: – Any agency – Nominated clinic	Type of Information *(including limits as applicable)* Examples: – All relevant information – Test results only	Purpose/s Examples: – Referral – Care coordination

Section 2: Record of Consumer Consent

2(a) Written Consumer Consent Or

The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers. I understand this and I give my informed consent for the information to be shared as detailed above.

Signed:

Dated: dd/mm/yyyy / /

Signed by:

☐ Consumer OR

☐ Authorised representative on behalf of:

(Consumer)

Witnessed by:

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

2(b) Verbal Consumer Consent

Worker/Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed with the consumer/consumer's authorised representative how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

To ensure the consumer/consumer's authorised representative is able to make an informed decision about consent to the sharing of information as detailed above, the worker/practitioner should: (tick when completed)

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *'Your Information – It's Private'* ☐
4. Provide the consumer with a copy of this form if requested (see guidelines) once completed ☐

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This information collected by:

Name: Position/Agency: -

Sign: Date: dd/mm/yyyy Contact number: