Client Information and Referral Record

Date

I.D. Number

To be used in accordance with the Guidelines and Principles

Client Information

Title

Full name

Prefers to be called

Usual Address

Street

Suburb State: Postcode

LGA SLA

Std Telephone No.

Current Address *(if different)*

Street

Suburb State: Postcode

LGA SLA

Std Telephone No.

Sex:

Country of birth

Ethnicity:

Date of Birth

Age

Language spoken at home:

Is language / Communicaton assistance required? No ☐ Yes ☐

Specify

Cultural or Religious affiliations

Yellow Book has been left with client ☐

Indigenous Status

- ○ Aboriginal but not Torres Strait Is.
- ○ Both Aboriginal and Torres Strait Is.
- ○ Torres Strait Is. but not Aboriginal
- ○ Neither Aboriginal or Torres Strait Is.

Source of referral

Name

Contact No.

Organisation (if applicable)

Source of referral:

Reason for referral and/or type(s) of assistance being sought

Is the client aware of the referral?

☐ Yes ☐ No

Is the carer aware of the referral ?

☐ Yes ☐ No ☐ N/A

What services are currently being received ?

What informal assistance is available on a regular basis (e.g. carer, friend, social club or church group)?

Name of service receiving referral

Referral received by

Action Required

Full Assessment ☐ Urgent ☐ ShortTerm ☐

Date | I.D. No./Name

Client Contacts

Name of person providing the details

Others present at assessment

First contact/Emergency contact person or carer

Telephone No. (home) | Telephone No. (work)

Address

Street:

Suburb: Postcode:

Relationship to client

Is there a carer? ☐ Yes ☐ No

Relation of Carer to Care Recipient:

Carer Residency Status:

GP's Name

Telephone No.

Name of formal guardian (if applicable)

Telephone No. (home) | Telephone No. (work)

Address

Street:

Suburb: Postcode:

2nd important contact

Telephone No. (home) | Telephone No. (work)

Relationship to client

3rd important contact

Telephone No. (home) | Telephone No. (work)

Relationship to client

Other Information

Client's usual living arrangements:

- Lives Alone
- Lives with Family
- Lives with Others
- Not stated/inadequately described

Accommodation Setting

Other (specify)

Private Health Insurance Company | Number

Ambulance Subscriber

☐ No ☐ Yes Type

Government benefit status:

- Aged Pension
- Veterens Affairs Pension
- Disability Support Pension
- Carer Payment Pension
- Unemployment related benefit
- Other government pension/benefit
- No government pension or benefit
- Not stated/inadequately described

Government Benefit Number

Pensioners Concession Card Number

Unable to determine ☐

Other (specify)

Does the client have a Department of Veterans' Affairs card?

Relevant Health Information

What does the client see as difficulties and/or health problems (eg hearing, allergies, incontinence) ?

How will any of these affect service delivery ?

Date ____ I.D. No./Name ____

Relevant Health Information (cont.)

Tasks of Daily Living

Please mark either an I, WA, D or NA

I	represents	"Independent"
WA	represents	"With assistance"
D	represents	"Dependent"
NA	represents	"Not applicable"

Task				
Shopping/Banking	☐ I	☐ WA	☐ D	☐ N/A
Preparing meals	☐ I	☐ WA	☐ D	☐ N/A
House work	☐ I	☐ WA	☐ D	☐ N/A
Minor home maintenance	☐ I	☐ WA	☐ D	☐ N/A
Use of telephone	☐ I	☐ WA	☐ D	☐ N/A
Transport	☐ I	☐ WA	☐ D	☐ N/A
Communication skills	☐ I	☐ WA	☐ D	☐ N/A
Community access	☐ I	☐ WA	☐ D	☐ N/A

Comments

Transport used

Car ☐ Taxi ☐ Bicycle ☐ Public Transport ☐

Other/Comment

Tasks of Self Care

Is assistance required with the following:

Task		
Bathe/Shower	☐ Yes	☐ No
Dress/Undress	☐ Yes	☐ No
Eat a meal	☐ Yes	☐ No
Grooming	☐ Yes	☐ No
Get in/out of bed	☐ Yes	☐ No
Use the toilet	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Footcare	☐ Yes	☐ No

Comments

Equipment used to maintain independence

Home and Safety and Access

Are there any factors about this home that could affect safety for/or access by:

Client ☐ Carer ☐ Service Provider ☐

Clients

continued

Carer

Service provider

Client Need and Referral Action

From the information gathered and in consultation with the client/carer, identify the client's needs

Identify carer's needs

Client Need and Referral Action (cont,)

To which service(s) is referral needed

- GP/Hospital ☐
- Home Nursing ☐
- Food services ☐
- Allied Health ☐
- Transport ☐
- ACAT ☐
- Day Hospital ☐
- Personal Care ☐
- Day Programs ☐
- Home Modification / Maintenance ☐
- Community Access ☐
- Home Help/Home Care ☐
- COPS/Linkages ☐
- Comm. Aged Care Packages ☐
- Respite (Home/Residential) ☐
- Recreational ☐
- Linen services ☐
- Social support services ☐

Other (e.g. advocacy or carer services)

What complementary assessments could assist (e.g. DNCB, DVA, Transport subsidy)

Agreed action of assessing service

Agreed referral action

Referring service notified of action taken

☐ Yes ☐ No

Note other information, literature, etc. provided

Client's Consent and Signature

I ______________________
(Client)

☐ consent ☐ do not consent

to this information being made available to the services nominated under Agreed Referral Action.

Signature Date

☐ Yes ☐ No

Comment if the client is unwilling or unable to sign (e.g. verbal agreement)

Review Date By Whom

Assessor Checklist

To be completed by person undertaking assessment

I ______________________
(Name)

acknowledge that I have:

- Informed the client/carer of the purpose of the assessment ☐
- Informed the client/carer of their rights and responsibilities ☐
- Outlined access to complaints mechanism and appeals process ☐
- Identified the outcomes of the assessment and formally obtained endorsement of proposed actions, including referral(s) ☐
- Advised that a copy will be left with them ☐

Signature Date

Contact No.

Organisation

Position in the Organisation

Date I.D. No./Name

Supplementary

Supplementary referral information:

Case Manager / Key Worker:

Client Type:

- Aged
- Younger Disabled
- Other

Dementia:

- No
- Suspected
- Diagnosed

Referral:

Priority

Comment

Comments: