CLIENT INFORMATION AND REFERRAL RECORD

Date

ID Number

To be used in accordance with the Guidelines and Principles

Client Information

Title

Full name

Prefers to be called

Usual Address

Std Telephone No

Street:

Suburb: State: Postcode:

LGA: SLA:

Current address *(if different)*

Std Telephone No

Street:

Suburb: State: Postcode:

LGA: SLA:

Sex: Country of birth: Ethnicity: Date of Birth Age

Language spoken at home:

Is language/communication assistance required? No ☐ Yes ☐

Specify

Cultural or Religious affiliations

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

Yellow Book has been left with client

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 (eg carer. friend, social club or church group)?

Name of service

Referral received by

Action required

Full Assessment ☐ Urgent ☐ Short Term ☐

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 ☐

Relationship 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
- ☐ Veterans Affairs Pension
- ☐ Disability Support Pension
- ☐ Carer Payment Pension
- ☐ Unemployment relation benefit
- ☐ Other govt pension or benefit
- ☐ No govt pension or benefit
- ☐ Not stated/inadequately described

Govt Benefit Number

Pensioner Concession Card No

Unable to determine ☐

Other (specify)

Does the client have a Dept of Veteran's 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?

Relevant Health Information (contd)

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

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	☐
Foot care	☐	Yes ☐	No	☐

Comments

[ ]

Comments

[ ]

Equipment used to maintain independence

[ ]

Transport used

Car ☐ Taxi ☐ Bicycle ☐ Public Transport ☐

Other/Comment [ ]

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

[ ]

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 (contd)

To which service(s) is referral needed

GP/Hospital	☐	Home Modification/ Maintenance	☐
Home Nursing	☐	Community Access	☐
Food Services	☐	Home Help/Home Care	☐
Allied Health	☐	COPS/Linkages	☐
Transport	☐	Comm. Aged Care Packages	☐
ACAT	☐	Respite (Home/Residential)	☐
Day Hospital	☐	Recreational	☐
Personal Care	☐	Linen Services	☐
Day Programs	☐	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 ofproposed actions, including referral(s) ☐

Advised that a copy will be left with them ☐

Signature Date

Contact No:

Organisation:

Position in the Organisation

Supplementary

Supplementary referral information:

Case Manager/
Key Worker:

Client Type:

- ☐ Aged
- ☐ Younger Disabled
- ☐ Other

Dementia:

- ☐ No
- ☐ Suspended
- ☐ Diagnosed

Additional Notes:

Comments:

TELEPHONE ASSESSMENT _____ (date)
Service:
Equipment Available:
HACC program code:
Priority:
Fee:
Debtor:
Additional Notes:

Health Status Checklist

For personal care and respite care customers, please classify the customer's health status for each of the following aspects using either "Stable", "No Problem", "Recent Change" or "Unsure".

A. Task Analysis/Manual Handling

1. Pain or discomfort
2. Breathlessness
3. Skin disorders/conditions
4. Sight
5. Hearing
6. Touch/sensation
7. Bladder function
8. Bowel function
9. Seizures
10. Dizziness