

Carer Referral Form

A carer provides unpaid care and assistance to a person who is frail aged, has dementia, a disability, a chronic illness, a mental illness or receives palliative care

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. Please phone 1800 052 222 to refer to the Commonwealth Respite & Carelink Centre

Carer details

Family Name _____

Given Names _____

Address _____

_____ P/code _____

Phone (H) _____ (W) _____

Mobile _____ Sex Male Female

Date of birth (dd/mm/yyyy) _____

Marital status _____

Employment status Casual Full time Part time
 Seasonal Not in paid employment

Relationship to Care Recipient (CR) _____

Co-resident Carer Yes No

Date caring role commenced / / or _____ (years)

Carer need High Moderate Low

Carer role Primary Other
 Not stated (inadequately described)

Time spent caring per week

Less than 20 hours 20-39 hours More than 39 hours

Current Formal Services received by Carer

Is not receiving services
 Is receiving a package
 Is receiving one or more formal services
 Not stated (inadequately described)

Informal Supports

Father Husband/male partner Other relative—male
 Mother Wife-female partner Other relative—female
 Daughter Daughter-in-law Friend/ neighbour—female
 Son Son-in-law Friend/ neighbour—male
 No informal support
 Not stated (inadequately described)

Country of birth

Australia Other (specify) _____

Language spoken at home

English Other (specify) _____

Interpreter required Yes No

Preferred language (if not spoken English) including sign language and any required communication devices or special interpreter needs (specify) _____

Indigenous Status

Aboriginal but not Torres Strait Islander origin
 Torres Strait Islander but not Aboriginal origin
 Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin

Government Pensioner / Benefit Status

Aged Pension Veterans Affairs Pension
 Disability Support Pension Carer payment (pension)
 No gov. pension or benefit Other gov. pension or benefit
 Unemployment related benefits

DVA Card Status No DVA card Yes (Gold)
 Yes (White) Yes (Other)

Care Recipient (CR), i.e. person being cared for

Name _____

Does the CR have a case manager/case coordinator

Yes No If yes, specify _____ (name)
_____ (phone) _____ (agency)

Assessments ACAS High Low HACC DHS Other

Care Recipient Diagnosis _____

Current Formal Services received by Care Recipient

Is not receiving services
 Is receiving one or more formal services
 Is using a package
 Not stated (inadequately described)

Primary Care Needs

Specific primary health care needs
 Acute health care needs
 Palliative care needs
 Rehabilitation needs
 Needs for ongoing management of chronic condition
 Extended (long-stay in special purpose facility) health care needs
 Psychogeriatric care needs
 Geriatric evaluation and management needs
 Maintenance care needs
 Other and unspecified needs
 Not stated (inadequately described)

Referral Information

Referral Completion Checklist

Carer information Yes
Consumer information Yes
Summary and Referral Yes
Carer / CR Consent Yes
Functional Assessment Yes
Other (specify) _____

Reason for Referral (please provide more information in Summary and Referral)