

# Confidential Referral Cover Sheet

Please acknowledge that you have received this referral by completing and signing below and returning via fax/email/mail

Date Sent: dd/mm/yyyy / /

Number of Pages (including cover sheet):

**Consumer**

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

## Referral to

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Organisation: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

Address: \_\_\_\_\_

## Agency/Service Provider sending referral

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Organisation: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email 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))

<input type="checkbox"/> Consumer Information (required)	<input type="checkbox"/> Summary and Referral (required)	<input type="checkbox"/> Consumer Consent
<input type="checkbox"/> Service Coordination Plan	<input type="checkbox"/> Living Arrangements Profile	<input type="checkbox"/> Functional Profile
<input type="checkbox"/> Health Conditions Profile	<input type="checkbox"/> Psychosocial Profile	<input type="checkbox"/> Health Behaviours Profile
<input type="checkbox"/> Functional Assessment Summary	<input type="checkbox"/> 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):

<input type="checkbox"/> Consumer declining	<input type="checkbox"/> Waiting list time inappropriate for consumer	<input type="checkbox"/> Ineligible for services	<input type="checkbox"/> Inappropriate referral	<input type="checkbox"/> Other
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If referral not proceeding provide additional comments below.

Comments and any further actions undertaken:

\_\_\_\_\_

Date Acknowledged: dd/mm/yyyy / /      Name: \_\_\_\_\_      Position: \_\_\_\_\_