



CarerLinks North

Commonwealth Carer Respite Centre NMR

PO Box 2021 Preston BC 3072 Tel: (03) 9495 2500 E-mail: cln@mchs.org.au

Intake Direct Tel: (03) 9495 2555 Fax: (03) 9495 2599

REFERRAL FORM

PLEASE PRINT CLEARLY

SOURCE OF REFERRAL

Please circle or tick (✓) as appropriate

Person making referral: _____ Ph: _____

Organisation: _____ Fax: _____

Do you wish to be contacted prior to our contact with carer? **Yes** **No**

How did you hear of CarerLinks North? _____

Has the carer consented to the referral? **Yes** **No**

Has the carer had any prior contact with CarerLinks North? **Yes** **No**

Has the carer consented to GP being contacted? **Yes** **No**

Does the carer or care recipient have a Case Manager/Co-ordinator? **Yes** **No**

CARER INFORMATION

First Name: _____ Surname: _____

Address: _____

Suburb: _____ Post Code: _____

Phone No: (H) _____ (W): _____

(M): _____

Sex: **M / F** D.O.B: _____

Country of Birth: _____ Preferred Language: _____

Interpreter? **Yes** **No** Dialect: _____

Indigenous Status: Aboriginal Torres Strait Islander None

Time Caring: Less 1 yr 1-3yrs 3-5yrs 5-10yrs 10+yrs

Source of Income: Pension (specify) _____ Employment Other

Carer Stress/Need: High Moderate Low

Carer Relationship to Care Recipient: _____

2nd Family Contact: Name: _____ Ph: _____

Name of GP: _____ Ph: _____

GP's Address: _____ Fax: _____

[Office use only]

Database

Date Referral Received: _____ Duty Worker: _____

Allocated Worker: _____ Carer Category: _____

Has the Carer given permission to refer to other services? **Yes** **No**

PLEASE PRINT CLEARLY

CARE RECIPIENT INFORMATION

Please circle or tick (✓) as appropriate

First Name: _____ Surname: _____

Address: _____

Suburb: _____ Post Code: _____

Phone No: (H) _____ (W): _____

_____ (M): _____

Sex: **M / F** D.O.B: _____

Country of Birth: _____ Preferred Language: _____

Interpreter? **Yes No** Dialect: _____

Indigenous Status: Aboriginal Torres Strait Islander None

Source of Income: Pension (specify) _____ Employment Other

DVA Entitlement? **Yes No** DVA No: _____

Care Need: High Moderate Low

Name of GP: _____ Ph: _____

GP's Address: _____

Care Recipient Condition/Diagnosis (Please do not use abbreviation)

Primary:
Secondary/Other:

Assessment (Please attach copy of assessment eg. CIARR or ACAS Form if relevant) Please include comments, date, who by and assessment outcomes eg. high/low care

ACAS/PGAT	<input type="checkbox"/> High Care <input type="checkbox"/> Low Care
HACC	
IDS Registration	
Other	
Case Managed? <input type="checkbox"/>	Name:
<input type="checkbox"/> Without Brokerage	Contact Details:

Services Currently Being Used

Service Provider	Service Provided	Frequency

Services Requested from CarerLinks North

(Please include exact times and dates if relevant)

Other Referrals Made

Service Provider/Name	Date of Referral	Services Requested

Current Issues

(Please include briefly indicators of carer stress)

Care Recipient Care Needs (Complete as appropriate)

	Independent	Assistance Needed (please specify)
Personal Care		
Nursing Needs		
Continence		
Mobility		
Communication		
Behaviour		
Sleeping		
Domestic Tasks		
Medication		
Banking, shopping, other		

Other Relevant Information

Eg: Other Family Members, Informal Supports, Cultural Issues
