**HOME CARE PACKAGE REFERRAL FORM**

Please return the completed form to referrals@yourcommunityhealth.org.au

|  |  |
| --- | --- |
| **Referral Date** |  |
| **Client Consent to Referral**  | [ ] Yes [ ] No |
| **Client Consent to Data Collection**  | [ ] Yes [ ] No |
| **Client Details** |
| **Name** |  |
| **DOB** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |
| **Gender Identity** | [ ] Female [ ] Male [ ] Non- Binary [ ] Transgender [ ] Prefer not to say [ ] Other: |
| **Aboriginal and/or Torres Strait Islander Origin** | [ ] Yes [ ] No |
| **Cultural Background** | Cultural Background: Preferred Language: Interpreter Required: [ ] Yes [ ] No |
| **Accommodation/Residential Setting** | [ ] Own Home [ ] Private Rental [ ] Supported Accommodation [ ] Nursing Home [ ] Other: |
| **Primary Contact**  | [ ] Client [ ] Next of Kin [ ] Client’s Representative [ ] Other: |
| **GP Details** |
| **Name** |  |
| **Address** |  |
| **Phone**  |  |
| **Case Manager or Referrer** |
| **Name** |  |
| **Organisation** |  |
| **Position/Title** |  |
| **Address** |  |
| **Phone** |  |
| **Email**  |  |
| **Next of Kin**  |
| **Name** |  |
| **Relationship to client** |  |
| **Address** |  |
| **Phone**  |  |
| **Email**  |  |
| **Referral Details** |
| **Medical History**  |  |
| **Risk Assessment** *(for home-based referrals only)* |  |
| [ ]  **Occupational Therapy** | [ ]  General home safety assessment [ ]  Falls prevention[ ] Equipment prescription [ ]  Home modificationsReason for referral: |
| [ ]  **Physiotherapy**  | [ ]  Mobility assessment [ ]  Falls and balance assessment [ ]  Gait/mobility aid prescription [ ]  Exercise programReason for referral: |
| [ ]  **Speech Therapy**  | [ ]  Communication assessment [ ]  Swallowing assessment Reason for referral: |
| [ ]  **Podiatry**   | [ ]  Nail and skin care [ ]  Diabetes assessment[ ]  Wound management [ ]  Advice on footwear [ ]  Orthotic / Biomechanical management [ ]  Nail SurgeryReason for referral: |
| [ ]  **Dietetics and Nutrition**  | [ ]  Nutrition adequacy assessment[ ]  Malnutrition [ ]  Dietary management of chronic conditions e.g. diabetes, gastro-intestinal disease)[ ]  Eating behaviours or feeding concernsReason for referral: |
| [ ]  **Social Support Program** | [ ]  Participate in social support groupsReason for referral: |
| **HCP Details** |
| **HCP Level** | [ ]  Level 4 [ ]  Level 3 [ ]  Level 2 [ ]  Level 1 |
| **Organisation**  |  |
| **Address**  |  |
| **Phone**  |  |
| **Accounts Email**  |  |