**HOME CARE PACKAGE REFERRAL FORM**

Please return the completed form to [referrals@yourcommunityhealth.org.au](mailto: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 modifications  Reason for referral: |
| **Physiotherapy** | Mobility assessment  Falls and balance assessment  Gait/mobility aid prescription  Exercise program  Reason 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 Surgery  Reason for referral: |
| **Dietetics and Nutrition** | Nutrition adequacy assessment  Malnutrition  Dietary management of chronic conditions e.g. diabetes, gastro-intestinal disease)  Eating behaviours or feeding concerns  Reason for referral: |
| **Social Support Program** | Participate in social support groups  Reason for referral: |
| **HCP Details** | |
| **HCP Level** | Level 4  Level 3  Level 2  Level 1 |
| **Organisation** |  |
| **Address** |  |
| **Phone** |  |
| **Accounts Email** |  |