CLIENT REFERRAL & MEDICAL HISTORY FORM

Thank you for your enquiry. For our team to provide appropriate customised quoting for your service requirements please complete the below pages and return to referral@careconnectorhouse.com.au. Once we receive the completed form, the team will prepare your quote and send it via email with a service agreement for approval.

☐ I, _____ have permission from the named client to provide their personal details and obtain quotes for services on their behalf.

How did you hear about us? -

CLIENT DETAILS

Client Full Name | **Client Number (eg: NDIS)** | **Date**

Client Address (including suburb and postcode)

Client Telephone | **Client Email** | **Client DOB** (DD/MM/YY)

Gender Identification
◯ Male ◯ Female ◯ Other

Interpreter Required?
◯ Yes ◯ No

Do you identify with Aboriginal or Torres Strait Islander (ATSI)? ◯ Yes ◯ No ◯ Prefer not to say

Do you identify as Culturally and Linguistically Diverse (CALD)? ◯ Yes ◯ No ◯ Prefer not to say

Preferred ADMINISTRATION CONTACT PERSON and contact details? (for our administration purposes)
◯ Client ◯ Support Coordinator ◯ Next of Kin ◯ Other

Preferred APPOINTMENT BOOKING CONTACT PERSON and contact details?
◯ Client ◯ Support Coordinator ◯ Next of Kin ◯ Other

Next of Kin / Support Person / Emergency Contact (Name, telephone and email)

CLIENT HISTORY

Primary Injury Type/ Condition / Diagnosis

Condition Details | **Date of Injury / Diagnosis**

GP Contact Details (**Name of Practice and Doctor, Telephone, email**) | **Allergies**

Do you have a current Emergency / Disaster Plan? (If yes please provide a copy) ◯ Yes ◯ No

FUNDING

Funding Type

◯ NDIS Self-Managed ◯ NDIS Plan-Managed ◯ NDIA-Managed ◯ NIISQ ◯ iCare Lifetime Care

◯ iCare Workers-Care ◯ iCare Self-Managed ◯ iCare Other ◯ Other

Support Coordinator / Case Manager
(Name, Company, telephone and email)

Plan Manager (Approves /Manages participant's funding for invoicing)
(Name, Company, telephone and email)

Plan Start Date

Plan End Date

Current Consumables Supplier

SERVICE REQUIREMENTS

What services do you require? ◯ Nursing Services ◯ Attendant Care/Support Services ◯ Both

Nursing Service Requirements

What service do you need? (Please select one or more)

☐ Continence Assessment ◯ In-home or ◯ Telehealth ☐ Continence Service ☐ Sex & Fertility ☐ Nutrition

☐ Wound Assessment ☐ Wound Services ☐ Other

Deadline for service to be delivered?

Attendant Care/Support Service Requirements

What service do you need? (Please select one or more)

☐ Personal Care ☐ Domestic Assistance ☐ Community Access/support ☐ Transport

☐ Other

Service Frequency? ◯ Daily ◯ Weekly ◯ Other **Service Term?** ◯ Ongoing ◯ Fixed period

Days Required? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Preferred start date for services **Hours required per shift?***

Details / Reason for referral Why do you need these services? What is your current medical situation?

*Please note 2 hour minimum service time per shift.

ADDITIONAL INFORMATION

Assessment Reports should be emailed to? (Please select one or more)

☐ Client ☐ Support Coordinator ☐ Plan Manager ☐ Next of Kin ☐ Other

Current Medications

Access for Services How is it best to access your home to provide services? Can our staff access your home easily? If not, please provide instructions. Is it safe for our staff to access you home, e.g. do you have animals, security etc. Will you have someone with you during our service?

Documents

☐ If available please provide copies of (which will be stored securely against the client's profile)

- ☐ NDIS or funders' goals
- ☐ Care Plan
- ☐ Discharge Plan
- ☐ Prior Assessments
- ☐ Emergency/Disaster Plan
- ☐ Positive Behavioural Support Plan
- ☐ Any other relevant docs

Additional information

Enduring Power of Attorney and/or Advance Health Directive

Do you have an Enduring Power of Attorney and/or Advance Health Directive? ◯ Yes ◯ No
If yes, please provide documentation