FORM A CLIENT REFERRAL FORM

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

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

CLIENT DETAILS

Client Full Name ______ **Client DOB** (DD/MM/YY) ______

Client Address (including suburb and postcode) ______

Client Telephone ______ **Client Email** ______

Preferred Method of Contact ? Phone Text Email Other ______

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

FUNDING

What type of funding do you have?

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

iCare Workers-Care iCare Self-Managed iCare Other Other ______

Client Number (eg: NDIS 43162XXX) ______

Plan Start Date (NDIS Required filed): ______

Plan End Date (NDIS Required field): ______

CONTACTS

Role	Name	Email	Contact Number
Support Coordinator/ Case Manager			
Plan Manager / Invoice Contact			
Next of Kin			
Advocate			

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CONTACT FOR QUOTE

Who should we send the quote to for review and approval? Client Support Coordinator Other

If Other, please provide details:

Name	Email	Contact Number	Role

CONTACT FOR INVOICES

Who should we send the invoices for payment to? Client Plan Manager Other

If Other, please provide details:

Name	Email	Contact Number	Role

CONTACT FOR CLIENT INTAKE/BOOKINGS

Once Approved, who is the contact for the Client intake/booking? Client Support Coordinator Other

If Other, please provide details:

Name	Email	Contact Number	Role

SERVICE REQUIREMENTS

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

Nursing Service Requirements

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

Continence Assessment Continence Service Sex & Fertility Nutrition

In-home or Telehealth

Wound Assessment Wound Services Other

Deadline for service to be delivered?

Attendant Care/Support Service Requirements

What services 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?***

*Please note 2 hours minimum service time.

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