# 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** | | | | | |
| **Client Email** | | **Client Telephone** | | | |
| **Preferred Method of Contact** | ◯ Phone ◯ Text Message ◯ Email ◯ Other: | | | | |
| **What type of funding do you have?** | ◯ NDIS Self-Managed ◯ NDIS Planned Managed ◯ NDIA-managed ◯ NIISQ<br>◯ iCare Lifetime Care ◯ iCare Dust Diseases Care ◯ iCare Workers-Care ◯ Other: _____ | | | | |
| **Client Number (eg NDIS 43162XXX)** | | **Plan start Date** | | **Plan End Date** | |
| **Primary Diagnosis** | | | | **Year of Diagnosis** | |
| **Details / Reason for referral** | | | | | |
| **Allergies** | | | | | |

| SERVICE REQUIREMENTS | |
|---|---|
| **What service do you require?** | ☐ HNS - Nursing Services ☐ HCS - Care Services ☐ HNS - Support Coordination Services ☐ HPM - Plan Management Services |
| **NURSING SERVICES - HNS** | |
| **What services do you need?** (select one or more) | ☐ Continence Assessment ☐ Continence Services ☐ Wound Assessment ☐ Wound Services<br>☐ Sex & Fertility Assessment ☐ Nutrition Services ☐ Other: _____ |
| **Deadline for Service to be delivered?** | |

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| CARE SERVICES - HCS (Attendant Care/Support) | | | |
|---|---|---|---|
| **What services do you require?** (select one or more) | ☐ Attendant Care ☐ High Intensity Care ☐ Personal Care & Community Access ☐ Other:_____ | | |
| **Duration of Services?** | ◯ 3 months ◯ 6 months ◯ 12 months ◯ Other: _____ | | |
| **Care Shift details*** *please include day and time ie Mon to Fri 6am to 2pm* *Please note 2 hours minimum service time. | | | |
| **Do you have any regular appointments or community access requirements?** | | | |
| **Estimated Start Date Required?** | | **Do you require transport during care shifts to appointments?** | Select |
| **OTHER DETAILS** | | | |
| **Any other details about the services required? (ie such as regular appointments)** | | | |

| CONTACT DETAILS | | | | |
|---|---|---|---|---|
| | **Name** | **Email** | **Telephone** | **Role** |
| **Support Coordinator/ Case Manager** | | | | *All Quotes sent for approval* |
| **Plan Manager / Invoice Contact** | | | | *All Invoices sent for payment* |
| **Next of Kin / Emergency Contact** | | | | |
| **Booking / Appointment Contact** | | | | *Who to contact for appointment bookings* |
| **GP Details** (Name of Practice and Doctor) | | | | |
| **Other Contacts** | | | | |