



care finder referral form

Thank you for referring your client. To help us understand your client's needs, please complete all sections of this referral form.

Date of referral:	Referrer name:		Referrer phone:		
Referrer email:		Referrer's rela	Referrer's relationship to client:		
Client details					
Title:	Family name:	First name:	Middle name:		
Gender:	Date of birth:	·	Estimated date of birth:		
Address:					
Street:	Suburb:		Postcode:		
Phone (home):		Phone (mobil	e):		
Country of birth:			Preferred language:		
Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No [lo 🗆 Unsure	Interpreter required: \square Yes \square No \square Unknown		
Is the client a person with	disability: □ Yes □ No □	Unsure			
If yes, what is the nature of	f their disability:				
If yes, is the client a NDIS	participant: ☐ Yes ☐ No	☐ Unsure			
Emergency contact					
Name:	Relationship	o:	Phone:		
Referral details					
Is the client eligible for Gov	vernment funded aged ca	re services? \square	Yes □ No □ Unsure		
My Aged Care ID number	if known:				
Does the client have an Aged Care package? ☐ Yes ☐ No ☐ Unsure					
Has the client undergone a RAS or ACAT assessment? ☐ Yes ☐ No ☐ Pending ☐ Unsure					
(either through the website	e, via phone through the c	ontact centre o	able to independently interact with My Aged Ca r face to face through Services Australia service nembers who can assist them in navigating My		
Does the client experience	one or more of the follow	ing challenges	?		
Isolation or no available support person			☐ Yes ☐ No ☐ Unsure		
Communication barriers, including limited health lite		literacy skills	☐ Yes ☐ No ☐ Unsure		
Difficulty processing information to make decisions		าร	☐ Yes ☐ No ☐ Unsure		
 Resistance or hesitancy government for any reas 		e, institutions, c	or □ Yes □ No □ Unsure		
Their safety is at risk, or	r they may end up in a cris	sis	☐ Yes ☐ No ☐ Unsure		





Please provide any relevant information that can assist us in supporting your clie Please outline any barriers to accessing My Aged Care and aged care supports a facing the client along with existing supports.	
I consent to the referral being made on my behalf Client signature:	Date:
Referrer signature:	Date:

Marathon Health is committed to protecting your information, and any information we collect is used to facilitate the services we provide to you.

- In providing high-quality services, we collect personal health information and maintain a client record.
- We follow the Australian Privacy Principles (APPs) contained in the Privacy Act 1988 when handling, using and managing personal information.
- The APPs also outline your rights relating to accessing or correcting your personal information.
- We will not sell, transfer, assign or rent your information to any third party without your permission, unless required by law.

	h professional with the client and/or authorised re ne proposed collection, use and disclosure of pe and disclosure.	
Referrer name	Referrer signature	// Date

Phone: 1300 418 223

Email: carefinder@marathonhealth.com.au

marathonhealth.com.au