

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 relationship to client:		
Client details					
Title:		Family name:		First name:	
Middle name:		Date of birth:		Estimated date of birth:	
Gender:		Date of birth:		Estimated date of birth:	
Address:					
Street:		Suburb:		Postcode:	
Phone (home):			Phone (mobile):		
Country of birth:			Preferred language:		
Aboriginal and/or Torres Strait Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Is the client a person with disability: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
If yes, what is the nature of their disability:					
If yes, is the client a NDIS participant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
Emergency contact					
Name:		Relationship:		Phone:	
Referral details					
Is the client eligible for Government funded aged care services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
My Aged Care ID number if known:					
Does the client have an Aged Care package? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
Has the client undergone a RAS or ACAT assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Unsure					
<i>To be eligible for the care finder program, the client needs to be unable to independently interact with My Aged Care (either through the website, via phone through the contact centre or face to face through Services Australia service centre) and does not have any family, friends or other community members who can assist them in navigating My Aged Care services</i>					
Does the client experience one or more of the following challenges?					
• Isolation or no available support person		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
• Communication barriers, including limited health literacy skills		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
• Difficulty processing information to make decisions		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
• Resistance or hesitancy to engage with aged care, institutions, or government for any reason		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
• Their safety is at risk, or they may end up in a crisis		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			

