CLIENT INFORMATION AND REFERRAL RECORD

Date ______ ID Number ______

To be used in accordance with the Guidelines and Principles

Client Information

Title | Full name | Prefers to be called

Usual Address | Std | Telephone No

Street:

Suburb: | State: | Postcode:

LGA: | SLA:

Current address *(if different)* | Std | Telephone No

Street:

Suburb: | State: | Postcode:

LGA: | SLA:

Sex: | Country of birth: | Ethnicity: | Date of Birth | Age

Language spoken at home:

Is language/communication assistance required? No ☐ Yes ☐ Specify

Cultural or Religious affiliations

Indigenous Status

☐	Aboriginal but not Torres Strait Is	☐	Both Aboriginal and Torres Strait Is
☐	Torres Strait Is but not Aboriginal	☐	Neither Aboriginal or Torres Strait Is

Yellow Book has been left with client

Name

Contact No.

Organisation (if applicable)

Source of referral:

Reason for referral and/or type(s) of assistance being sought

Is the client aware of the referral?

☐ Yes ☐ No

Is the carer aware of the referral?

☐ Yes ☐ No ☐ N/A

What services are currently being received?

What informal assistance is available on a regular basis (eg carer. friend, social club or church group)?

Name of service

Referral received by

Action required

Full Assessment ☐ Urgent ☐ Short Term ☐

Date ID No/Name

Client Contacts

Name of person providing the details

Name of formal guardian (if applicable)

Others present at assessment

Telephone No (home) Telephone No (work)

First contact/Emergency contact person or carer

Address

Street:

Suburb: Postcode:

Telephone No (home) Telephone No (work)

2nd important contact

Address

Street:

Suburb: Postcode:

Telephone No (home) Telephone No (work)

Relationship to Client

Relationship to Client

Is there a carer? Yes ☐ No ☐

3rd important contact

Relationship of Carer to Care Recipient

Telephone No(home) Telephone No (work)

Carer Residency Status

GP's name

Relationship to Client

Telephone No

Other Information

Client's usual living arrangements

☐ Lives alone ☐ Lives with family

☐ Lives with others ☐ Not stated/inadequately described

Accommodation setting

Other (specify)

Private Health Insurance Company Number

Government benefit status:

☐ Aged Pension

☐ Veterans Affairs Pension

☐ Disability Support Pension

☐ Carer Payment Pension

☐ Unemployment relation benefit

☐ Other govt pension or benefit

☐ No govt pension or benefit

☐ Not stated/inadequately described

Govt Benefit Number

Pensioner Concession Card No

Unable to determine ☐

Other (specify)

Ambulance Subscriber
☐ No ☐ Yes Type

Does the client have a Dept of Veteran's Affairs Card?

Relevant Health Information

What does the client see as difficulties and/or health problems (eg hearing, allergies, incontinence)?

How will any of these affect service delivery?

Relevant Health Information (contd)

Tasks of Daily Living
Please mark either an **I**, WA, D or NA

I	represents	"Independent"
WA	represents	"With assistance"
D	represents	"Dependent"
NA	represents	"Not applicable"

Task	I	WA	D	N/A
Shopping/Banking	☐	☐	☐	☐
Preparing meals	☐	☐	☐	☐
House work	☐	☐	☐	☐
Minor home maintenance	☐	☐	☐	☐
Use of telephone	☐	☐	☐	☐
Transport	☐	☐	☐	☐
Communication skills	☐	☐	☐	☐
Community Access	☐	☐	☐	☐

Tasks of Self Care
Is assistance required with the following:

Task		Yes	No
Bathe/Shower	☐	☐	☐
Dress/Undress	☐	☐	☐
Eat a meal	☐	☐	☐
Grooming	☐	☐	☐
Get in/out of bed	☐	☐	☐
Use the toilet	☐	☐	☐
Walking	☐	☐	☐
Foot care	☐	☐	☐

Comments

Comments

Equipment used to maintain independence

Transport used
Car ☐ Taxi ☐ Bicycle ☐ Public Transport ☐

Other/Comment

Home and Safety and Access

Are there any factors about this home that could affect safety for/or access by:
Client ☐ Carer ☐ Service Provider ☐

Clients

Carer

Service Provider

Client Need and Referral Action

From the information gathered and in consultation with the client/carer, identify the client's needs

Identify carer's needs

Date ____ ID No/Name ____

Client Need and Referral Action (contd)

To which service(s) is referral needed

Service	☐	Service	☐
GP/Hospital	☐	Home Modification/ Maintenance	☐
Home Nursing	☐	Community Access	☐
Food Services	☐	Home Help/Home Care	☐
Allied Health	☐	COPS/Linkages	☐
Transport	☐	Comm. Aged Care Packages	☐
ACAT	☐	Respite (Home/Residential)	☐
Day Hospital	☐	Recreational	☐
Personal Care	☐	Linen Services	☐
Day Programs	☐	Social Support Services	☐

Other (e.g. advocacy or carer services)

What complementary assessments could assist (e.g. DNCB, DVA, Transport subsidy)

Agreed action of assessing service

Agreed referral action

Referring service notified of action taken

☐ Yes ☐ No

Note other information, literature, etc. provided

Client's Consent and Signature

I ____
(Client)

☐ consent ☐ do not consent

to this information being made available to the services nominated under Agreed Referral Action.

Signature:

☐ Yes ☐ No

Date

Comment if the client is unwilling or unable to sign (e.g. verbal agreement)

Review Date	By Whom

Assessor Checklist

To be completed by person undertaking assessment

I _____
(Name)

acknowledge that I have:

- Informed the client/carer of the purpose of the assessment ☐
- Informed the client/carer of their rights and responsibilities ☐
- Outlined access to complaints mechanism and appeals process ☐
- Identified the outcomes of the assessment and formally obtained endorsement ofproposed actions, including referral(s) ☐
- Advised that a copy will be left with them ☐

Signature Date

Contact No:

Organisation:

Position in the Organisation

Date I.D. No/Name

Supplementary

Supplementary referral information:

Case Manager/
Key Worker:

Client Type:

- ☐ Aged
- ☐ Younger Disabled
- ☐ Other

Dementia:

- ☐ No
- ☐ Suspended
- ☐ Diagnosed

Additional Notes:

Comments:

TELEPHONE ASSESSMENT _____
(date)

Service:

Equipment Available:

HACC program code:

Priority:

Fee:

Debtor:

Additional Notes:

OH&S Risk Assessment

OH&S Risk Assessment conducted over phone or in field ?

Please answer "Yes", "No" or "NA" to the questions below.

A. Task Analysis/Manual Handling

1. Are any medications to be administered supplied in chemist issued bubble packs (i.e. Webster packs)?
2. Can the customer transfer from bed to chair independently?
3. In the bed, can the customer roll, move across the bed, sit up and get out of bed independently?
4. When showering, can the customer step over the hob, transfer on and off the shower chair as necessary?
5. When toileting, can the customer transfer on and off the toilet, assist with hygiene and clothing, and balance independently?
6. Can the customer assist with dressing?
7. Has any requested maintenance therapy been assessed recently as safe? (training for employees may be required)
8. Do service tasks avoid repetitive movements?
9. Can one employee safely manage tasks? (two employees may be required, or manual handling equipment)
10. Can employees safely move any objects required in service? (i.e. trolleys, chairs, etc)
11. Can the employee access the customer to assist with washing and drying, as necessary?

B. Workplace/Residence

Please assess all areas employees will work in, including outdoors

1. Are the floors accessed by employee's intact, non-slip, free of trip hazards?
2. Are steps and stairs in good condition, with hand rails and non-slip surfaces?
3. Are power points and electric cords intact, easily accessed and not overloaded?
4. Does the lighting allow employees to conduct work, enter and exit safely?
5. Is there enough space to conduct service safely and avoid over-reaching, twisting or other unsafe postures?
6. Are any risks related to animals (pets, vermin) controlled by the owner (ie.entry/exit to residence is safe)?
7. Does anyone in the household smoke?

Please answer "Yes", "No" or "NA" to the questions below.

C. Equipment

1. Can the vacuum cleaner be safely accessed, moved and operated by the employee?
2. Does the mop and bucket meet OHS requirements?
3. Are any household appliances to be used by employees in good working order and can they be operated safely e.g. washing machine, iron, etc)?
4. Are food preparation tools safe?
5. Are laundry baskets and trolleys able to be moved safely? (consider load, free movement of wheels, paths to be negotiated)
6. Is the bathroom fitted with rails, non-slip surfaces, and labelled taps?
7. Are hot water supplies free of hazards?
8. Is manual-handling equipment provided to avoid manual lifts?
9. Do shower chairs and bath boards meet safety standards?
10. Are chemicals to be used in service labelled clearly and designed for household use?
11. Does the house have heating and is this functioning? (To determine time of day to deliver service.)
12. Does the house have cooling and is this functioning? (To determine time of day to deliver service.)

D. Customer and family

1. Have you assessed if there are any other issues which impact on the health, safety and wellbeing of our employees while they are in this workplace?

Health Status Checklist

For personal care and respite care customers, please classify the customer's health status for each of the following aspects using either "Stable", "No Problem", "Recent Change" or "Unsure".

A. Task Analysis/Manual Handling

1. Pain or discomfort
2. Breathlessness
3. Skin disorders/conditions
4. Sight
5. Hearing
6. Touch/sensation
7. Bladder function
8. Bowel function
9. Seizures
10. Dizziness