|  |
| --- |
| Referrer Details |
| Provider Name: |       |
| Referring Person Name: |       |
| Position: |       |
| Phone: |       | Email: |       |
| Recipient Details |
| First Name: |       | Surname: |       |
| Address: |       | Postcode: |       |
| Contact Number: |       | Mobile: |       |
| Date of Birth: |    /    /      | Age: |       |
| Gender: | [ ]  Male | [ ]  Female | Country of Origin: |       |
| Main Language Spoken: |       | Other languages: |       |
| Current Housing Situation: | [ ]  Homeless | [ ]  Housing Stress | [ ]  Insecure Accommodation | [ ]  Other |
| Please provide details: |       |
| Special Needs Groups |
| To assist us in our reporting please indicate if the care recipient identifies as being from one or more of the following groups. Special needs groups are defined under the Aged Care Act 1997 as people who: |
| [ ]  | Are from Aboriginal and Torres Strait Islander communities. | [ ]  | Are financially or socially disadvantaged |
| [ ]  | Are from culturally and linguistically diverse backgrounds | [ ]  | Are homeless, or at risk of becoming homeless |
| [ ]  | Are Veterans | [ ]  | Are care leavers (including Forgotten Australians, Former Child Migrants and Stolen Generations). |
| [ ]  | Are lesbian, gay, bisexual, transgender or intersex | [ ]  | Are parents separated from children by forced adoption or removal. |
| [ ]  | Care Leavers | [ ]  | Live in rural and remote areas. |
| Health Status |
| Please provide details if the recipient has any of the following health concerns: |
| Mobility: |       |
| Hearing: |       |
| Continence: |       |
| Eyesight: |       |
| Dementia: |       |
| Speech: |       |
| Drug/Alcohol Issues: |       |
| Mental Health: |       |
| Territory Housing Application Submitted: | [ ]  Yes | [ ]  No | [ ]  Unknown |
| Background Details |
| Best way to contact client: |
|       |
| Family Background: |
|       |
| Income: |
|       |
| Do they have a carer? If so, please give details: |
|       |
| Any Further Details |
|       |
| Recipient Signature: |  | Date: |    /    /      |
| Office Use Only |
| Date Referral Received: |    /    /      |
| Care Finder Officer Comments: |
|       |