Community Connections Program

Care Partner Referral Form

RDNS
Part of Silver Chain Group

Phone: 1300 295 673 | Fax: 1300 295 679

Email: RDNSACCReferrals@rdns.org.au

Details of person being referred

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: Client Title (

Surname: Client Surname

Given name(s): Client Given Name (s)

Preferred name(s):

Sex: ☐ 1 Male ☐ 2 Female ☐ 9 Not stated

DOB: Client DOB Estimate Age Estimate Age

Usual Address: Usual Address inc postcode

Postal Address: Postal address inc postcode

Phone (Home): Home Phone Number

Marital status

☐ 1 Never married ☐ 2 Widowed ☐ 3 Divorced
☐ 4 Separated ☐ 5 Married/Defacto ☐ 9 Not known

Accommodation setting

☐ 1 Home Owner ☐ 2 Private Rental ☐ 3 Public
☐ 5 ILU ☐ 6 Boarding House
☐ 19 Other Other Accommodation

Pension Type 10/12/2021

Pension Number 10/12/2021

Health insurance ☐ Yes ☐ No ☐ Unknown

Extras Ambulance ☐ Yes ☐ No ☐ Unknown

Cover ☐ Yes ☐ No ☐ Unknown

Compensable ☐ Yes ☐ No ☐ Unknown

Country of birth Country of Birth

Indigenous status

☐ 9 Not stated
☐ 1 Aboriginal, not TSI ☐ 2 TSI, not Aboriginal
☐ 3 Both ☐ 4 Neither Aboriginal, nor TSI

Primary language Primary Language

Interpreter required ☐ Yes ☐ No ☐ Unknown

If yes, details: Interpreter details

Carer Availability

☐ Has a carer ☐ 2 Has no carer ☐ 9 Not stated

Carer Relationship

☐ 1 Wife/Female Partner ☐ 2 Husband/Male Partner
☐ 3 Mother ☐ 4 Father
☐ 5 Daughter ☐ 6 Son
☐ 7 Daughter-in-law ☐ 8 Son-in-law
☐ 9 Other Relative – Female ☐ 10 Other Relative, Male
☐ 11 Friend/Neigh – Female ☐ 12 Friend/Neigh, Male

Date of Referral: Date of Referral

Carer Residency

☐ 1 Co-Resident ☐ 2 Non-Resident ☐ 9 Not stated

Usual Living Arrangements

☐ 1 Lives alone ☐ 2 Lives with Family
☐ 3 Lives with others ☐ 9 Not stated

Details of person making referral

Name: Name of person making the referral

Organisation: Organisation

Program Name: Program Name

Relationship to person being referred: Relationship to person be

Phone: Phone number of person referring

Client aware of referral & consenting to referral: ☐ Yes ☐ No

No, reason client unaware: Reason client is unaware

If referred by hospital:

Ward No: Ward number

Admission Date: Discharge date:

Contact person for the client being referred

Name: Name of contact person

Is this person the client's carer? ☐ Yes ☐ No

Is this person nominated to be at assessment? ☐ Yes ☐ No

Does this person reside with the client? ☐ Yes ☐ No

If no, Address: If no, Address:

Phone(Home): Contact Person HOME Phone

Phone(Work): Contact Person WORK Phone

Mobile: Contact Person MOBILE Phone

E-mail: Contact Person EMAIL

Relationship to client

☐ 1 Spouse/Partner ☐ 2 Daughter/Son ☐ 3 Parent
☐ 4 Sibling ☐ 5 Other Relative ☐ 6 Friend
☐ 8 Not stated ☐ 9 Other

Comments: relationship to client - COMMENTS

GP Details

Name: GP Name

Address: GP Address

Phone: GP Phone Fax: GP phone

E-mail: GP Email

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Client Name: Client Given Name (s)	Client Surname	**Date of Birth**: Client DOB

Diagnoses/ Past Medical History:

Diagnosis/Past Medical History

☐ **Palliative approach to care**

☐ **Predicted prognosis** (in weeks) Predicted Prognosis (weeks)

Referral request/Services requested:

Referral Request/Services Requested

Presenting Problem/Issues:

Presenting Problem/s

Current Services

Service Type	**Organisation/Contact Details**
Service Type 1	Organisation/Contact Details 1
Service Type 2	Organisation/Contact Details 2
Service Type 3	Organisation/Contact Details 3
Service Type 4	Organisation/Contact Details 4

Notification of Referral

Do you require notification of the outcome of the referral: ☐ Yes ☐ No

If yes, please indicate your preferred method of contact

☐ Fax Fax number (method of contact)

☐ Email Email address (method of contact)