THERAPY CIRCLES
AUSTRALIA
SURROUND YOURSELF WITH CARE

# HOME CARE REFERRAL FORM

## PARTICIPANT DETAILS

Full name

Date of birth (DD / MM / YYYY)

/ /

Gender

Male Female Other

Aged Care Number (ACN)

Address

Phone

Mobile

Email

## REPRESENTATIVE/GUARDIAN

Full name

Relationship

Email

Contact Number

## EMERGENCY CONTACT

Full name

Relationship

Email

Contact Number

## NEXT OF KIN

- ◯ Same as representative/guardian
- ◯ Same as emergency contact
- ◯ Enter next of kin details below

Full name

Relationship

Email

Contact Number

## MEDICAL POWER OF ATTORNEY

- ◯ Same as representative/guardian
- ◯ Same as emergency contact
- ◯ Same as next of kin
- ◯ Enter medical power of attorney details below

Full name

Relationship

Email

Contact Number

## LIVING ARRANGEMENTS & CULTURAL BACKGROUND

**Current Living Arrangements** (With family, alone, or sharing with others)

**Cultural Background**

- ◯ Torres Strait Islander
- ◯ Aboriginal
- ◯ Aboriginal & Torres Strait Islander
- ◯ None of the above
- ◯ Culturally and Linguistically Diverse (CALD) (Please specify below)

**Details (if applicable)** (Share details of your cultural background if you wish)

# HOME CARE REFERRAL FORM

**Is an interpreter required?** (For you or your representative) ◯ Yes ◯ No

## DIAGNOSIS

Please Provide Details if Applicable

**Primary Diagnosis**

**Secondary Diagnosis/Comorbidities**

**Current Treatments or Medications**

**Does The Individual Have Epilepsy, Seizures, Asthma, Allergies?**

**Assistance Required With Mobility E.g., Wheelchair, Walker, Hoists?**

**Details Of Past Hospital Admissions**

**Any Details Of Past Therapists?**

**Any Other Safety Concerns, Or Behaviours Of Concern Etc.?**

## SOURCE OF REFERRAL

◯ Self ◯ Family ◯ Other

**Referrer full name**

**Referrer phone**

**Referrer email**

# HOME CARE REFERRAL FORM

## MEDICAL CONTACTS

Main Doctor/GP full name

Clinic name

Contact Number

I Grant Permission To Access My Medical Records

- ◯ Yes
- ◯ No

## REASONS FOR THIS REFERRAL

- ◯ Physiotherapy
- ◯ Occupational Therapy
- ◯ Speech Pathology
- ◯ Therapy Assistants

If you have requested Speech Pathology, are you experiencing any of the following problems?

- ◯ Swallowing difficulties
- ◯ Trouble learning
- ◯ Trouble finding the right words
- ◯ Memory difficulties
- ◯ Voice difficulties
- ◯ Trouble starting/finishing tasks
- ◯ Hearing difficulties
- ◯ Difficulty being understood by others
- ◯ Trouble understanding others
- ◯ Other

Preference For Male/Female Practitioner

- ◯ Male
- ◯ Female
- ◯ No preference

# HOME CARE REFERRAL FORM

## FUNDING

Level of Home Care Package

- ◯ Level 1
- ◯ Level 2
- ◯ Level 3
- ◯ Level 4

**Frequency of Services (optional)** (e.g., once a week, fortnightly, monthly)

## CLOSEST BRANCH

- ◯ Geraldton WA
- ◯ Girrawheen WA
- ◯ Gosnells WA
- ◯ Joondalup WA
- ◯ Mandurah WA
- ◯ Midland WA
- ◯ Osborne Park WA
- ◯ Rockingham WA
- ◯ Sunshine VIC
- ◯ Werribee VIC
- ◯ Not sure

How did you hear about us?

## RELEVANT DOCUMENTS

When sending your referral, please include any relevant documents including previous therapy reports, clinical care plans, screenshots of medication list.

# HOME CARE REFERRAL FORM

## OFFICE USE ONLY

Referral Outcome ◯ Referral Accepted ◯ Referral not Accepted

Name/Position

## ACCEPTED

Details

Allocation Date

Date entered on the database

Notes

## NOT ACCEPTED

Details

Reason not accepted

**Comments/Actions** e.g., referred on to [name of service]