Aged Care Client Details Form

Question? Call us on 02 6651 2143

Referral details

Date of referral			
Referrer name		Contact number	
Referral source	☐ Self ☐ Relative/Friend ☐ OT ☐ HCP ☐ Other		
How did the client hear about us?			

Client Information

Surname		Given Name/s	
Gender ☐ Female ☐ Male ☐ Other			
Address:			
Date of Birth		Place of Birth	
Home phone:		Mobile number:	
Interpreter required? ☐ Yes ☐ No		Main language	
Aboriginal? ☐ Yes ☐ No		Torres Strait Islander? ☐ Yes ☐ No	
Medicare Number		Veterans Card Colour	
Pension ☐ Aged ☐ Disability ☐ DVA ☐ Self-funded ☐ Other			
MAC referral code			

Carer Details

Surname		Given Name/s	
Relationship to client			
Gender: ☐ Female ☐ Male ☐ Other			
Address		Suburb	
Home phone		Mobile number	
Date of Birth		Place of Birth	
Interpreter required? ☐ Yes ☐ No		Main language	
Residential Status: ☐ Co-resident ☐ Non-resident			
Aboriginal? ☐ Yes ☐ No		Torres Strait Islander? ☐ Yes ☐ No	
Does the carer care for more than one? ☐ Yes ☐ No			

Aged Care Client Details Form

Question? Call us on 02 6651 2143

Emergency Contact

Surname		Given Name/s	
Relationship to client			
Address			
Suburb			
Home phone:		Mobile number:	

GP/Referral Details

GP Details		Referral Details	
Name		Name	
Date		Date	
Address		Agency	
Suburb		Days of work	
Postcode		Email	
Phone number		Phone	
		Mobile	

Client Living Arrangements

☐ Alone ☐ Spouse/partner only ☐ With Relatives ☐ Other			
Name			
Phone		Email	

Tenure

☐ Own Home
☐ With Family
☐ Rents Private
☐ Social Housing
☐ Other

Case Manager - contact details:

Landlord/Body Corporate/Housing permission must be given in writing for private/public rental situations. *Please attach an authority to Install sheet with the referral.*

Aged Care Client Details Form

Question? Call us on 02 6651 2143

Is the Client in Receipt of Home Care Package?

☐ Yes ☐ No	Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4
If yes, Package Provider Name and Contact Details:	

Functional Disability

Disability	☐ Yes ☐ No	Frail Aged	☐ Yes ☐ No
Dementia	☐ Yes ☐ No	Hearing Aides	☐ Yes ☐ No
Frame	☐ Yes ☐ No	Wheeled Walker	☐ Yes ☐ No
Wheelchair	☐ Yes ☐ No	Walking Stick	☐ Yes ☐ No
Palliative	☐ Yes ☐ No		
Other (specify):			

What are the Implications for the client if work is not completed?

☐ Reduced independence	☐ Risk of injury to self or others
Details:	

Communication preferences:

☐ Phone call	☐ Text message	☐ Email	☐ Home visit	☐ Office visit
☐ Other:				

Confidentiality Statement

This is to inform you that information collected by the Commonwealth Home Support Program (CHSP) and Coffs Harbour Home Modification and Maintenance Inc (trading as Accessibility Experts) is required by the funding body the Commonwealth Department of Health. This information is used for research and planning purposes and will not affect supports you are eligible to receive. Identifying information such as name and address will NOT be forwarded to any department.

Aged Care Client Details Form

Question? Call us on 02 6651 2143

Client/Carer Consent

I, …… ☐ client ☐ carer ☐ advocate
Address:
Consent to this referral being lodged with Accessibility Experts and any relevant information in this referral being made available to mutually agreed supports, including other CHSP support provided by Accessibility Experts other CHSP or Home Care Package related partnership programs provided through Accessibility Experts entities contracted by Accessibility Experts to provide supports to clients

Signature:	Date:
Verbal Agreement if client is unable to sign: ☐ Yes ☐ No	
I agree to photos and/or footage taken of me by Accessibility Experts to be printed and published in any material anywhere and at any time without limit: ☐ Yes ☐ No	
Signature:	Date:

Safety and access information

Is there adequate parking available?			YES	☐	NO	☐
Are animals restrained?	N/A	☐	YES	☐	NO	☐
Is there mobile phone reception/signal at the participants home address?			YES	☐	NO	☐
Are there any other access or safety issues to be aware of?			YES	☐	NO	☐
If yes, provide details						