Aged Care Referral Form

Meet and Greet Date _______________

Participant's Details

Given Name/s		Surname	
Phone No.		Date of Birth	
Full Address			
Aged Care Number		Referral Code	
Gender		Living Condition	
Working Status		Marital Status	
Contact Person	[ ] Participant [ ] Other (*mention)*		
Referred By			

Participant's Representatives

Next of Kin Name			
Next of Kin Phone		Relationship	
GP Name		GP Phone	

Participant's Condition/Requirements

Home Care Level		Do you have an approval letter?	
Mobility Status (Ask "Are you able to move by yourself or require assistance or any equipment)	[ ] Independent [ ] Single Assist [ ] Double Assist [ ] Uses Frame [ ] Wheel Chair [ ] Bed Bound		
Types of Services Required	[ ] Personal Care [ ] Domestic Assistance [ ] Respite Care	[ ] Community Access [ ] Gardening [ ] Others	
Do you have any sensory impairment?			
Do you have any special/psychological needs?			
Preferred Language		Preferred Gender	
Need for Transport (Car)		Need for Overnight Stay	

Additional Information

Supreme Care
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OH&S Risk Inquiry

Are you on any kind of medication		
Are you a smoker?		
Do you have history of drug/alcohol abuse?		
Do you require communication assistance?		
Is there any weapons/firearms on premises?		
Is there an access code to the premise?		
Is the premise located in fire danger area?		
Are there are any pets in the premise?		
Any smokers in the house		
Is there anyone in or around the house who may cause concern for staff safety?		

Other Notes