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Family and Community Services

REFERRAL FORM

Referring Agency:			
Contact Name:		Contact Phone:	
Email Address:			
Date:		Time:	

Contact ☐ Carer ☐ Referring Agency ☐ Other

Urgency: ☐ Urgent ☐ Non-Urgent

Has the Carer or Recipient has given permission for referral and to pass this information to other service providers?

☐ Yes ☐ No

Carer Details

Name:			
Date of Birth:		Gender:	☐ Male ☐ Female ☐ X
Address:			
Postal: (if different)			
Phone Home:		Work:	
Mobile:		Fax:	
Email Address:			

Living Arrangements: ☐ Alone ☐ Family ☐ Other ☐ Not stated

Carer Status:
☐ Sole Carer in the household
☐ One identified Carer in the household with other care support eg siblings, other family
☐ Two identified Carers in the household

Please describe

Country of Birth:

Indigenous status: ☐ None ☐ Aboriginal ☐ Torres Strait Islander ☐ Not stated

CALD	☐ No	☐ Yes	Nationality:		
Pension/Benefit Type:					

Relationship of Carer to Care Recipient

Care Recipient Details

Name:					
Date of Birth:		Gender:	☐ Male	☐ Female	☐ X
Address:					
Postal: (if different)					
Phone Home:		Work:			
Mobile:		Fax:			
Email Address:					
Living Arrangements:	☐ Alone	☐ Family	☐ Other	☐ Not stated	
Country of Birth:					
Indigenous status:	☐ None	☐ Aboriginal	☐ Torres Strait Islander	☐ Not stated	
CALD	☐ No	☐ Yes	Nationality:		
Pension/Benefit Type:					

Disability/Illness:

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Formal services used by Carer and/or Care Recipient

Agency	Service Type	Contact Details

Reason for Referral

- ☐ Counselling
- ☐ Advice
- ☐ Education & Training
- ☐ Respite
- ☐ Social Support
- ☐ Carer wellbeing (level of burden/stress)
- ☐ Referral & Linkage
- ☐ Other – please describe

Issues Impacting on Caring

Carer's emotional health:

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Carer's physical health:

Carer's wellbeing (level of stress):

Financial issues impacting on caring:

Additional information:

Submit