HOME AND COMMUNITY CARE REFERRAL FORM

For people under 65 years of age OR Aboriginal or Torres Strait Islander people under 50

Civic Centre, Corner Young & Davey Streets, Frankston, Vic, 3199
Phone: 9784 1933 Fax: 9784 1770
Email: intake@frankston.vic.gov.au Web: www.frankston.vic.gov.au

Please fax or email the completed referral form

CLIENT DETAILS

Last Name:	**First Name:**
Title: ☐ Mrs ☐ Ms ☐ Miss ☐ Mr	**Date of Birth:** _____ / _____ / _____
Street Address:	
Suburb:	**Postcode:**
Phone:	**Mobile:**

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Non-binary/Non-conforming ☐ Prefer not to say

Is Client of Aboriginal or Torres Strait Islander origin? ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither
IMPORTANT: If YES and Client is 50 years or over, referral must be made via My Aged Care

Income type: ☐ Disability Support Pension ☐ Carer Payment ☐ Carer Allowance ☐ Jobseeker ☐ Parenting Payment ☐ Other Please state: _____

Department of Veterans Affairs (DVA): ☐ Gold ☐ Blue ☐ White ☐ Orange ☐ Other ☐ None

Has the Client registered for NDIS (National Disability Insurance Scheme)? ☐ Yes ☐ No ☐ Unknown

If YES, what is the status? ☐ Access met ☐ Plan approved ☐ Did not meet access

CARER DETAILS

Does client have a Carer? ☐ Yes ☐ No

If YES, Carer Last Name:	**Carer First Name:**
Carer Phone:	**Carer Mobile:**
Carer Street Address:	
Suburb:	**Postcode:**
Carer Date of Birth: _____ / _____ / _____	**Relationship to Client:**

Is Carer in receipt of Carer Payment or Allowance? ☐ Yes ☐ No

Is Carer in receipt of another Centrelink Payment? ☐ Yes ☐ No If YES, type:_____

ALTERNATIVE / EMERGENCY CONTACT	
Last Name:	**First Name:**
Phone:	**Mobile:**
Street Address:	
Suburb:	**Postcode:**
Relationship to client:	

REFERRER	
Organisation:	
Last Name:	**First Name:**
Address of organisation:	
	Post Code:
Phone:	**Mobile:**
Fax:	**Email:**

SERVICE TYPE REQUESTED

- ☐ **Meals on Wheels**
- ☐ **Shopping (escorted)**
- ☐ **Shopping (unescorted)**
- ☐ **Home Care (Domestic Assistance)**
- ☐ **Community Transport (Shopping/Library bus)**
- ☐ **Personal Care**
- ☐ **In-Home Respite Care**
- ☐ **Home Maintenance (Handyman)**
- ☐ **Social Support**
- ☐ **MEPACS (Personal alarm)**

PRIORITY

☐ **Low** ☐ **Medium** ☐ **High** ☐ **Urgent** (immediate risk to Client health or safety)

Priority Comment / Reason:

RISK
Any known or perceived risks to Client:
Any known or perceived risks to Frankston City Council Staff:
Any known barriers to communication:

SIGNIFICANT CLIENT HISTORY	
Client lives alone or with others	
Owns or rents home	
Mobility, are any walking aids used, walking stick, walker	
Brief description of what support is required with daily living tasks	
Current health concerns	

OTHER RELEVANT INFORMATION

CONSENT
Does client consent to referral? ☐ Yes ☐ No
Signature of Referrer: **Date:**