

ACT Client Information and Referral Record

To be used in accordance with the Guidelines and Principles

Date
/ /

I.D Number

Client Information

Title Full Name Name preferred to be called

Usual Address
No. Street Telephone No.
Suburb Postcode

Current Address (if different)
No. Street Telephone No.
Suburb Postcode

Female Country of birth Ethnicity Date of birth Age
Male / /

Language spoken at home Is language/communication assistance required? No Yes Specify

Cultural or religious affiliations Does the client identify themselves as an Aboriginal or Torres Strait Islander person? Yes No

Source of referral

Name

Contact No.

Organisation (if applicable)

Reason for referral and/or type(s) of assistance being sought

Is the client aware of the referral?
Yes No

Is the carer aware of the referral?
Yes No

Signature of referring person

What services are currently being received?

What informal assistance is available on a regular basis (e.g. carer, friend, social club or church group)

Name of service receiving referral	Referral received by
<input type="text"/>	<input type="text"/>

ACTION REQUIRED

Full assessment Urgent Short term

Client/Carer Need and referral Action (cont.)

To which service(s) is referral needed

- | | |
|--|--|
| GP Hospital <input type="checkbox"/> | Home Modification/
Maintenance <input type="checkbox"/> |
| Home Nursing <input type="checkbox"/> | Community access <input type="checkbox"/> |
| Food Services <input type="checkbox"/> | Home help/Home care <input type="checkbox"/> |
| Allied Health <input type="checkbox"/> | COPS/Linkages <input type="checkbox"/> |
| Transport <input type="checkbox"/> | Comm. Aged Care Package <input type="checkbox"/> |
| ACAT <input type="checkbox"/> | Respite (home/residential) <input type="checkbox"/> |
| Day Hospital <input type="checkbox"/> | Recreation <input type="checkbox"/> |
| Personal Care <input type="checkbox"/> | Linen services <input type="checkbox"/> |
| Day Program <input type="checkbox"/> | Social support services <input type="checkbox"/> |

Other (e.g. advocacy or carer services)

What complementary assessments could assist

(e.g. DNCB, DVA, Transport subsidy)

Agreed action of assessing service

Agreed referral action

Referring service notified of action taken

Yes No

Note other information, literature etc. provided

Client/carers consent and signature

I _____,
Client/Carer

- Consent to the information on this form being made available to the services nominated under agreed Referral Action. I understand these services may pass information to other parties where necessary for the delivery of nominated services.
- Consent to participating in the national Home and Community Care Client Information Collection. (Minimum Data Set). This consent extends to all services nominated under Agreed Referral Action.
- DO NOT Consent to participating in the National Home and Community Care Client Information Collection (Minimum Data Set)

Signature

	Date / /
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Comment if the client is unable to sign
(e.g. verbal agreement)

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Review Date

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By whom

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Assessor Checklist

To be completed by person undertaking assessment

I _____

Acknowledge that I have:
Informed the client/carer of the purpose of the assessment

Informed the client/carer of their rights and responsibilities

Outlined access to complaints mechanism and appeals process

Identified the outcomes of the assessment and formally obtained endorsement of proposed actions, including referral(s)

Advised that a copy will be left with them

Signature

	Date / /
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Contact No.

Organisation

Position in organisation