

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

VERSION 7
(Faxing to External Referrers)

Consumer

Name: _____

Date of Birth: dd/mm/yyyy / /

Sex: _____

UR Number: _____

or affix label here

Consumer details

Family Name: _____

Given Names: _____

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? _____ Code:

Preferred Name/s: _____

Sex: _____ Code: Title: _____

Contact Address (for correspondence, home visits etc.)

Usual Address (if different from contact address)

Contact phone number/s
(check preferred number)

Can leave message?

Home: () Yes No

Work: () Yes No

Mobile: Yes No

Email: Yes No

Country of Birth: _____ Code:

Indigenous Status: _____ Code:

Need for Interpreter Services: _____ Code:

Preferred Language: _____ Code:

Communication Method: _____ Code:

General Practitioner (if no GP, write NA)

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name: _____

Contact Address

Phone numbers

Home: _____

Work: _____

Mobile: _____

Relationship to Consumer: _____ Code:

Is this person the consumer's carer? _____ Code:

Person 2 Name: _____

Address: _____

Phone: _____

Government Pension/Benefit Status: _____ Code:

Health Care Card Holder Status: _____ Code:

Card number: _____

Medicare Card:

Card number: _____

Health Insurance Status:

Insurer name: _____

Card number: _____

DVA Card Entitlement:

DVA card type: _____ Code:

DVA card number: _____

Compensables Funding Source: _____ Code:

Comments:

CONSUMER INFORMATION FOR CAULFIELD ACCESS REFERRAL

Place Patient ID label here



CAULFIELD GENERAL
MEDICAL CENTRE

A Member of
BAYSIDE HEALTH

MR CAULFIELD ACCESS REFERRAL (Page 1 of 3)

DATE: / / COMPLETED BY: CONSENT TO SHARE INFORMATION: Yes No

REFERRAL SOURCE:

LIVING AND CARING ARRANGEMENTS

Living Arrangements (Define family/others)

Lives alone

Lives with family

Lives with others

Carer Availability

Has a carer

Has no carer

Is the carer for somebody else

Carer Residency Status

Not applicable

Co-resident carer

Non-resident carer

Risk to Carer Arrangements

Yes

No

Unsure

Accommodation Type (e.g. comment on private/public, MOH, Hostel)

Please identify any potential risk factors for staff visiting this client at home.

Employment Status (eg. Student / employed / unemployed / retired)

REASON FOR REFERRAL / DIAGNOSIS

Date of Onset / Injury / Operation: / /

Relevant Past History (Attach relevant information including investigations if available)

Date of Discharge (if current inpatient):

Estimated Number of Falls in last 12 months:

Serious Injury as a Result of a Fall

Yes

No

Frequent Near Falls

Yes

No

Cause of Fall

Relevant Medications (Attach list if available)

CAULFIELD ACCESS REFERRAL



Place Patient ID Label

MR
CAULFIELD ACCESS REFERRAL (Page 2 of 3)

FUNCTIONAL INFORMATION/CONCERN (Refer to D/C summary if attached)

Please define with comments if the client is having difficulties with any of the following:

Mobility / Transfers

Personal / Domestic / Community ADL's

Vision/hearing

Social (Include finances, social activites, counselling needs, substance abuse)

Medication Management

Cognition

Behavioural / Mood Issues

Continence

Nutrition (Include diet, weight changes)

Speech (Include communication, swallowing)

Pain (Include diagnosed and undiagnosed)

Other Comments

CAULFIELD ACCESS REFERRAL



Place Patient ID label here

MR CAULFIELD ACCESS REFERRAL (Page 3 of 3)

SUPPORT SERVICES INVOLVED AT TIME OF DISCHARGE

Agencies / Services	Contact Details / Comments
<input type="checkbox"/> ACAS	
<input type="checkbox"/> Aged Psychiatry Services	
<input type="checkbox"/> Carer Respite Service	
<input type="checkbox"/> C'wealth Packages eg. CACPS	
<input type="checkbox"/> Community Health	
<input type="checkbox"/> HACCC eg. HH, MOW	
<input type="checkbox"/> HARP	
<input type="checkbox"/> PAC eg. Allied Health, H/H, PCA	
<input type="checkbox"/> Nursing Services eg. RDNS	
<input type="checkbox"/> Other	

REFERRED TO:

<input type="checkbox"/>	Caulfield Community Health Service	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> CHN <input type="checkbox"/> SP <input type="checkbox"/> SW <input type="checkbox"/> Diet <input type="checkbox"/> Podiatry <input type="checkbox"/> Strength Training <input type="checkbox"/> Psych <input type="checkbox"/> Outreach <input type="checkbox"/> Paediatrics
<input type="checkbox"/>	Caulfield Community Rehabilitation Centre	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> CHN <input type="checkbox"/> SP <input type="checkbox"/> SW <input type="checkbox"/> Diet
<input type="checkbox"/>	Therapy In The Home	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> CHN <input type="checkbox"/> SP <input type="checkbox"/> SW <input type="checkbox"/> Diet
<input type="checkbox"/>	Falls Clinic	
<input type="checkbox"/>	CDAMS	
<input type="checkbox"/>	Continence Clinic	
<input type="checkbox"/>	Cardiac Rehabilitation	
<input type="checkbox"/>	Pain Management	

PLEASE DEFINE GOALS TO BE ACHIEVED BY PROGRAM:

Name:	Designation:
Agency:	E-mail:
Phone:	Fax:

CAULFIELD ACCESS REFERRAL