ACT Client Information and Referral Record

To be used in accordance with the Guidelines and Principles

Date

I.D Number

Page 1

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	Specify			
	communication N.			
assistance red	quired? No Yes L			
Cultural or religious affiliations Does the clie	ent identify themselves as an			
	r Torres Strait Islander person? Yes No			
	Page 1a			
	1 age 1a			
Source of referral	Is the client aware of the referral?			
Name	Yes No			
Name	res no			
Contact No.	Is the carer aware of the referral?			
Organisation (if applicable)	Yes No			
(if applied to	Signature of referring person			
Reason for referral and/or type(s) of assistance being sought	What services are currently being received?			
being sought				
	What informal assistance is available on a regular			
	basis (e.g. carer, friend, social club or church group)			
	Name of service Referral			
	receiving referral received by			
	ACTION REQUIRED			
	Full assessment Urgent Short term			

		I.D. No./Name	Page 2
Client Contacts	Client Co	ntacts	
	Name of person providing details	Name of formal guardian	(if applicable)
Name of person providing details Name of formal guardian (if applicable)	Others present at assessment	Telephone No. (home)	Telephone No. (work)
	First contact/emergency contact person or carer	Address	
Others present at assessment Telephone No. (home) Telephone No. (work) First contact/emergency contact person or carer Address	Telephone No. (home) Telephone No. (work)	Suburb	Postcode
Others present at assessment Telephone No. (home) First contact/emergency contact person or carer Address No. Street	Relationship to client Carer Yes No	GP's Name	
Others present at assessment Telephone No. (home) First contact/emergency contact person or carer Address No. Street Suburb Postcode Relationship to client Carer GP's Name	Address No. Street	Telephone No.	
Others present at assessment First contact/emergency contact person or carer Telephone No. (home) Address No. Street Suburb Postcode GP's Name GP's Name Telephone No. (work)	Suburb Postcode 2 nd Important contact	3 rd important contact	
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Others present at assessment Telephone No. (home) Telephone No. (work) First contact/emergency contact person or carer Address	Telephone No. (home) Telephone No. (work)		Postcode
	First contact/emergency contact person or carer		
Name of person providing details Name of formal guardian (<i>if applicable</i>)	Others present at assessment	Telephone No. (home)	Telephone No. (work)
			(if applicable)
		I.D. No./Name	Page 2

	Da	ite	I.D. No./Nar	ne	
Rel	vant F	Health I	nformation (cont.)		Page 3
Tasks of daily Living	vant 1	icartii i	Tasks of self care		
Please circle either an I, WA, D, or NA:					
I represents "Independent"			Is assistance required	l with the follow	wing:
WA represents "With assistance"					
D represents "Dependent"			Bathe/Shower	Yes	No 🗌
N/A represents "Not applicable"			Dress/Undress	Yes	No
Shopping/Banking I WA	D	N/A			
Preparing meals I WA	D	N/A	Eat a meal	Yes	No L
House work I WA	D	N/A	Grooming	Yes	No 🗌
Minor home maintenance I WA	D	N/A	Get in/out of bed	Yes	No 🗌
Use of the telephone I WA	D	N/A			
Transport I WA	D	N/A	Use the toilet	Yes	No L
Communication skills I WA	D	N/A	Walking	Yes L	No L
Community access I WA	D	N/A	Footcare	Yes	No 🗌
Community access 1 WA	D	1 \ / A	rooteure		110
Comments			Comments		
Comments			Comments		
Transport			Equipment used to	maintain indep	endence
Car Taxi Bicycle Public tra	nsport				
Other/comment					
					Page 3a
	Home	and Saf	ety and Access		Ü
	_		_		
Are there any factors about this home that	t coulc	l affect	Carers		
safety/for access by:					
Client Carer Service pro	viders				
Clients			Service providers		
			1		
Clian	t/Conc	n Nood	and referral Action		
			and referral Action		
From the information gathered and in convicts the alient/source identify the alient's		on	Idantify agnor's no	.d.	
with the client/carer, identify the client's	neeus		Identify carer's nee	eus	
		Dat	e I.D. No	o./Name	

To which service(s) is referral needed	Agreed action of assessing service
GP Hospital Home Modification/ Maintenance	
Home Nursing Community access	
Food Services Home help/Home care	
Allied Health COPS/Linkages	
Transport Comm. Aged Care Package	
ACAT Respite (home/residential)	Agreed referral action
Day Hospital Recreation	
Personal Care Linen services	
Day Program Social support services	
Other (e.g. advocacy or carer services)	
	Referring service notified of action taken Yes No
What complementary assessments could assist	Note other information, literature etc. provided
(e.g. DNCB, DVA, Transport subsidy)	
Client/carer's con	Page 4a
Client/carer's con	Page 4a
I	· ·
 Client/Carer Consent to the information on this form being non Referral Action. I understand these services may the delivery of nominated services. Consent to participating in the national Home and the services. 	nade available to the services nominated under agreed
Consent to the information on this form being not Referral Action. I understand these services may the delivery of nominated services. Consent to participating in the national Home as (Minimum Data Set). This consent extends to a	nade available to the services nominated under agreed y pass information to other parties where necessary for and Community Care Client Information Collection.
Client/Carer Consent to the information on this form being in Referral Action. I understand these services may the delivery of nominated services. Consent to participating in the national Home as (Minimum Data Set). This consent extends to a DO NOT Consent to participating in the Nation Collection (Minimum Data Set)	nade available to the services nominated under agreed y pass information to other parties where necessary for and Community Care Client Information Collection.
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		Date I.D. No./Name	D 5
A	ssessor (Checklist	Page 5
To be completed by person undertaking assessm	nent	Signature	Date
Acknowledge that I have: Informed the client/carer of the purpose of the assessment		Contact No.	/ /
Informed the client/carer of their rights and responsibilities			
Outlined access to complaints mechanism and appeals process		Organisation	
Identified the outcomes of the assessment and formally obtained endorsement of proposed actions, including referral(s)		Position in organisation	
Advised that a copy will be left with them			
Informed the client/carer that their information will be handled in accordance with the agency's Privacy & Confidentiality Policy	3		
Informed the client/carer that they may refuse the services & reapply at any time without disadvantaging themselves in any way			
Informed the client/carer that they have the right to involve an advocate to act on their behalf at any time.			
Informed client/carer that their services will be reviewed and monitored by the case worker			
Informed the carer of services available to support their needs.			
Informed client/carer/guardian/advocate of Fees Policy			
Provided client with envelopes for transport			