

REFERRAL - INDIVIDUAL CLIENT PAGE 1

Ability Assist

TAKEN BY

DATE REF

Thank-you for for filling in this form. It will help us provide a quality service. When the 4 pages are filled in

FAX TO: (03) 9383-5277 OR

EMAIL: clients@abilityassist.com.au

CLIENT DETAILS

| | | | |
|----------|----------------------|----------|----------------------|
| NAME | <input type="text"/> | PHONE | <input type="text"/> |
| ADDRESS | <input type="text"/> | D.O.B | <input type="text"/> |
| SUBURB | <input type="text"/> | MELWAY | <input type="text"/> |
| POSTCODE | <input type="text"/> | KEY CODE | <input type="text"/> |

PARENTS OR CARERS DETAILS IF APPLICABLE

| | | | |
|------------|----------------------|-------|----------------------|
| CARER NAME | <input type="text"/> | PHONE | <input type="text"/> |
| NOTE | <input type="text"/> | | |

REFERRER DETAILS

| | | | |
|--------------|----------------------|-------|----------------------|
| NAME | <input type="text"/> | PHONE | <input type="text"/> |
| ORGANISATION | <input type="text"/> | FAX | <input type="text"/> |
| ADDRESS | <input type="text"/> | EMAIL | <input type="text"/> |
| SUBURB | <input type="text"/> | | |
| POSTCODE | <input type="text"/> | | |

CASE MANAGER

REFERERER IS CASE MANAGER

| | | | |
|--------------|----------------------|-------|----------------------|
| NAME | <input type="text"/> | PHONE | <input type="text"/> |
| ORGANISATION | <input type="text"/> | FAX | <input type="text"/> |
| ADDRESS | <input type="text"/> | EMAIL | <input type="text"/> |
| SUBURB | <input type="text"/> | | |
| POSTCODE | <input type="text"/> | | |

SERVICE REQUEST

| | | | |
|---------------|--------------------------|--------------------|--------------------------|
| PHYSIO | <input type="checkbox"/> | ATTENDANT CARE | <input type="checkbox"/> |
| OT | <input type="checkbox"/> | PERSONAL CARE | <input type="checkbox"/> |
| SPEECH T | <input type="checkbox"/> | RECREATION | <input type="checkbox"/> |
| BEHAVIOUR MGT | <input type="checkbox"/> | EMPLOYMENT SUPPORT | <input type="checkbox"/> |
| OTHER | <input type="text"/> | | |

ONGOING SERVICE

START DATE

END DATE

Monday

Thursday

Tuesday

Friday

Wednesday

Saturday

Sunday

HOURS / WEEK

ONGOING/ONE OFF ONGOING ONE OFF

DESCRIPTION

WORKER PREFERRED MALE

FEMALE

EITHER

OTHER IMPORTANT PHONE NUMBERS

| NAME | ORGANISATION | CONTACT | PHONE |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

WHO DO WE SEND THE BILL TO?

SEND INVOICE TO TO REFERRER

DHS CLIENTS

Please tick funding source

NAME

SERVICE AGREE

ORGANISATION

DESCRETIONERY

ADDRESS

DAS

SUBURB

HOMEFIRST

POSTCODE

SUPPORT & CHOICE

PHONE

SUPPORT & CHOICE

FAX

EMAIL

through serv agree

through broker

05 - F - 02

REFERRAL - INDIVIDUAL CLIENT PG 2

| | | | | |
|-------------------|--------------|--------------------------|---------|--------------------------|
| DISABILITY | INTELLECTUAL | <input type="checkbox"/> | VISION | <input type="checkbox"/> |
| | PHYSICAL | <input type="checkbox"/> | HEARING | <input type="checkbox"/> |
| | PSYCHIATRIC | <input type="checkbox"/> | ABI | <input type="checkbox"/> |

DESCRIPTION

ACTIVITIES OF DAILY LIVING

| | | |
|--|--|--|
| MOBILITY | GROOMING | TOILETTING |
| Walks independantly <input type="checkbox"/> | independent <input type="checkbox"/> | independent <input type="checkbox"/> |
| Wheech electric <input type="checkbox"/> | Requires Assistance <input type="checkbox"/> | Requires Assistance <input type="checkbox"/> |
| Wheech manual <input type="checkbox"/> | Dependent <input type="checkbox"/> | Dependent <input type="checkbox"/> |
| Walk with frame <input type="checkbox"/> | <hr/> | <hr/> |
| Min assist required <input type="checkbox"/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |

| | | |
|--|--|--|
| COMMUNICATION | EATING | DRESSING |
| Verbal <input type="checkbox"/> | independent <input type="checkbox"/> | independent <input type="checkbox"/> |
| Signing <input type="checkbox"/> | Requires Assistance <input type="checkbox"/> | Requires Assistance <input type="checkbox"/> |
| Good receptive <input type="checkbox"/> | Dependent <input type="checkbox"/> | Dependent <input type="checkbox"/> |
| Simple commands <input type="checkbox"/> | <hr/> | <hr/> |
| Yes / No <input type="checkbox"/> | <hr/> | <hr/> |
| Gestures <input type="checkbox"/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |
| <hr/> | <hr/> | <hr/> |

| | | |
|---|--|---|
| COMMUNITY ACCESS | HUMAN RELATIONS | EQUIPMENT |
| Absconder <input type="checkbox"/> | Interacts voluntarily <input type="checkbox"/> | Surgical Boots <input type="checkbox"/> |
| Wanderer <input type="checkbox"/> | Accepts interaction <input type="checkbox"/> | Wheelch <input type="checkbox"/> |
| Road Safety Skills <input type="checkbox"/> | Needs encouragement <input type="checkbox"/> | Frame <input type="checkbox"/> |
| Supervsion in cars <input type="checkbox"/> | Dislikes interaction <input type="checkbox"/> | Splints/Calipers <input type="checkbox"/> |
| Travel in driver only vehicle <input type="checkbox"/> | <hr/> | <hr/> |
| In car/taxi with staff support <input type="checkbox"/> | <hr/> | <hr/> |
| Uses public transport <input type="checkbox"/> | <hr/> | <hr/> |

MEDICATION

Adminstration by staff

PRN

Allergies

Epilepsy

Illness

Diabetes

Dietry

Other

REFERRAL - INDIVIDUAL CLIENT PG 3

CHALLENGING BEHAVIOUR

Self Injurious _____

Aggressive _____

Property damage _____

Absconds _____

Useful strategies _____

LIKES

DISLIKES

ACTIVITIES OR OTHER PROGRAMS

ALERTS

EMERGENCY CONTACT

NAME

PHONE

CLIENT NAME _____

LOCATION OF SERVICE _____

DESCRIPTION
ACCESS OUTSIDE BROKEN OR UNEVEN SURFA
 TRIP HAZARDS
 SAFELY ACCESSIBLE

| YES | NO |
|-----|----|
| | |
| | |
| | |

COMMENT

ACCESS INSIDE BROKEN OR UNEVEN SURFA
 TRIP HAZARDS
 SLIPPERY FLOORS
 SAFELY ACCESSIBLE

| YES | NO |
|-----|----|
| | |
| | |
| | |

APPLIANCES

| | |
|---------------|--|
| FRIDGE | Comment on working order, plugs, cords |
| HEATER | |
| WASHING MACH | |
| MICROWAVE | |
| STOVE | |
| OVEN | |
| ELECTRICAL OU | |
| SMOKE DETECT | |
| KETTLE | |

| satisfactory | unsatisfactory |
|--------------|----------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

COMMENT

EQUIPMENT

| | |
|--------------|---|
| HOIST | Comment on handle length, state of repair |
| MOP | |
| BUCKETS | |
| VACUUM CLEAN | |
| BROOM | |
| CLEANING EQU | |

| satisfactory | unsatisfactory |
|--------------|----------------|
| | |
| | |
| | |
| | |
| | |
| | |

COMMENT

PETS

| | |
|--------|-------------------------------------|
| DOG/S | Comment on existence and aggression |
| CAT/S | |
| BIRD/S | |

| satisfactory | unsatisfactory |
|--------------|----------------|
| | |
| | |
| | |

COMMENT

SMOKERS
 IN HOUSEHOLD

| YES | NO |
|-----|----|
| | |

SHARPS
 SAFE STORAGE AND DISPOS

| YES | NO |
|-----|----|
| | |

MANUAL HANDLING

IS THERE CLIENT MANUAL H
 IS THERE HOISTING
 IS ADDITIONAL STAFF TRAINING REQUIRED

DESCRIBE MANUAL HANDLING/HOISTING REQUIREMENTS

| YES | NO |
|-----|----|
| | |
| | |
| | |

FILLED IN BY: _____ **DATE:** _____

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