Carer Programs ‘Event Only’ Registration Form

This form is to be used for registering Carer/Care Recipient participants of Carer Program events or Service Enhancement Funded events. Please ensure that you complete all fields on this form as this is the Minimum Data required for event processing. ***Accepted only as a Word Document (not PDF)***

**Referee Details**

|  |
| --- |
| Name: |
| Position and Organisation: |
| Phone: |
| Email Address: |

**Consent**

|  |
| --- |
| Carer and Care Recipient consent to this referral for events and activities:  Yes |

**Event Details**

|  |  |
| --- | --- |
| Name of Event: | Date of Event: |
| Carer Program Event:  **or/** Service Enhancement Event: | |

**Carer Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: Choose an item. | Surname: | | | First Name: | |
| DOB: | Marital Status: Choose an item. | | | | |
| Address: | | | | | Postcode: |
| Phone Number: | | | Mobile Number: | | |
| Country of Birth: | | | Indigenous Status: Choose an item. | | |
| CALD:  Yes  No | | Interpreter Required:  Yes  No | | Language spoken at home: | |
| Pension Type: Choose an item. Other: | | | DVA Card: Yes No | | |
| Carer Role Start Date: | | | Relationship of Carer to Care Recipient: | | |
| Living Arrangement: Choose an item. | | | Carer need: Choose an item. | | |
| Employment Participation: Choose an item. | | | Co-resident Carer: Yes No | | |
| Accommodation Setting: Choose an item. | | | | | |
| Carer Diagnosis: | | | | | |

**Care Recipient Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title: Choose an item. | | Surname: | | | First Name: | |
| DOB: | | Marital Status: Choose an item. | | | | |
| Address: | | | | | | Postcode: |
| Phone Number: | | | Mobile Number: | | | |
| Country of Birth: | | | Indigenous: Choose an item. | | | |
| CALD: Yes No | Interpreter Required: Yes No | | | Language spoken at home: | | |
| Pension Type: Choose an item. | | | DVA: Yes No | | | |
| Employment Status: Choose an item. | | | Living Arrangements: Choose an item. | | | |
| Accommodation Setting: Choose an item. | | | | | | |
| **Diagnosis:** | | | | | | |

This form is to be submitted ***via S2S*** or ***emailed*** to LCHS Gateway at [ServiceAccessReferrals@lchs.com.au](mailto:ServiceAccessFaxReferrals@lchs.com.au)

Contact Carer Programs Clinical Lead on 1800 242 696 with any queries.