|  |  |
| --- | --- |
|  | Case Management Linkages Referral Form |

**Submit this form via S2S** or, if not available, email to: ServiceAccessReferrals@lchs.com.au

(*Press F11 to move between text boxes when completing*)

**Client details:** *(If question is irrelevant or information not known, write Not Applicable or N/A)*

|  |  |
| --- | --- |
| **Family Name**:       | **Referral Completion Checklist:**[ ]  Yes [ ]  NoThis Page[ ]  Yes [ ]  NoCarer/Consumer Consent**Referrer Details:****Name**:      **Organisation**:      **Email**:      **Phone**:       |
| **Given Names**:       |
| **Preferred Name/s**:       |
| **Date of birth:** *(dd/mm/yyyy)*       |
| **Gender**:       |
| **Address**:       |
|       **P/Code**:       | **GP**:      **Phone**:      **Consent to contact**? [ ]  Yes [ ]  No |
| **Phone:**       **Mobile:**        |
| **Email**:       | **Source of Referral:** Choose an item. |
| **Client diagnosis/disability:**       |
| **Country of Birth:**Record: (1) Australia (2) Other      If other, please specify:       | **Living Arrangements:**Choose an item. |
| **Indigenous Status:**Choose an item. | **Accommodation Setting:**Choose an item.  |
| **Main Language Spoken at Home:** Record: (1) English (2) Other      If other, please specify:       | **Employment Status:**Choose an item. |
| **Interpreter Required:** Record: (1) Interpreter not required       (2) Interpreter needed | **Income Type:**Choose an item. |
| **Preferred Language:** (if not spoken English)*Including sign language & any required communication device or special interpreter needs.*      | **DVA Card Status:**Choose an item. |

**-2-**

**Current service and supports:**

|  |
| --- |
| **Current services and support networks in place**: *(eg HACC PYP, Allied Health, family support)*       |
| **Financial concerns impacting services or supports:**       |
| **New or additional support needed to maintain independence**:       |
| **Assessments completed**: Allied health [ ]  HACC PYP [ ]  Other *(please specify)* [ ]        |
| **NDIS referral status**: New [ ]  Declined [ ]  Review [ ]  N/A [ ]  Other *(please specify)*  [ ]        |
| **Are there any relevant appointments scheduled in?**: [ ]  Yes *(eg NDIS Review)*       [ ]  No |

|  |
| --- |
| **Client Issues – Reason for Referral:** *(including level of urgency)*      |

**Additional Information:**

|  |
| --- |
| **Safety concerns or anything else to be aware of**:        |

 **Carer/Guardian details if applicable:**

|  |
| --- |
| **Name**:       |
| **Date of birth:** *(dd/mm/yyyy)*       |
| **Address**:       |
| **Phone Number** :       |
| **Relationship to client**:       | **Co-resident of client**: [ ]  Yes [ ]  No |
| **Carer/Guardian concerns**:       |
| **Carer supports in place**:       |