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|  | Case Management Linkages Referral Form |

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

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| **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. |

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**Current service and supports:**

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| **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 |

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

**Additional Information:**

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

**Carer/Guardian details if applicable:**

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| **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**: | |