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|  | Carer Program Referral Form  Definition: A carer provides unpaid care and assistance to a person with frailty, disability, chronic illness or mental illness  If question is irrelevant or information not known, write Not Applicable or NA |

Complete this form where a client has an identified primary carer who is experiencing stress, financial, emotional or lifestyle pressures because of their caring role. 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

**Referral Details**

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| **Suggested Referral Urgency** *please tick* | **Carer Consent for this referral**  Yes  No |
| **High** – select reason below  Imminent risk of caring relationship breaking down  Person who needs care has a palliative illness with rapid decline  Person who needs care has a stable palliative illness, significant carer stress  Urgent safety concern  **Moderate urgency**  **Non-urgent**  **Event only referral** |
| **Referrer Name**:  **Organisation**:  **Email**:  **Phone**:  **Date of Referral:**  **Source of Referral:** Choose an item. |

**Carer details:**

|  |  |  |
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| **Family Name**: | | **Date of birth:** *(dd/mm/yyyy)* |
| **Given Names**: | | **Gender**: |
| **Preferred Name/s**: | | **Phone:**       **Mobile:** |
| **Address**: | **P/Code**: | **Email**: |
| **Relationship to Person who needs care:**  Choose an item. | | **Emergency Contact:** Relationship:  Name:  Phone: |
| **Country of Birth:**  Australia  Other If other, specify: | | **Preferred Language:**  English  Other If other, specify:  Interpreter required  Yes  No  Comments: |
| **Indigenous Status:**  Choose an item. | |

**Impact on Caring:**

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| **Carer wellbeing (level of burden/stress**): |
| **Carer’s physical health**: |
| **Financial issues impacting on caring**: |
| **Current services involved**: |

**Carer Issues – Reason for Referral**

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| (Carer support/navigating services, short-term in-home supports, carer events/education, include details of urgency)  **Carer Events  Carer Supports**  **Details:** |

**Additional Information:**

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| **Are there any safety concerns with the Carer or Person with care needs, or anything else to be aware of**? |

**Cares for:**

|  |  |
| --- | --- |
| **Family Name**: | **Date of birth:** *(dd/mm/yyyy)* |
| **Given Names**: | **Gender**: |
| **Preferred Name/s**: | **Phone:**       **Mobile:** |
| **Address**: | **P/Code**: |
| **Country of Birth:**  Australia  Other  If other, specify: | **Preferred Language:**  English  Other If other, specify:  Interpreter required  Yes  No  Comments: |
| **Indigenous Status:**  Choose an item. |
| **Person with Care Needs Diagnosis/health concerns**: | |
| **Does Person with Care Needs have services in the home through a Case Managed Package?**  Yes  No  Support at Home Package: Level:  NDIS  Other *(example DVA/ TAC)*  **Case manager/co-ordinator details**?  *Our funded supports are limited when a Person who needs care is already in receipt of a Case Managed Package. Carers are welcome to be referred for general carer support, education, events and activities.* | **Assessments**:  Clinical Assessment (ACAS)  Non-Clinical Assessment (RAS – Home Support)  Other Assessment:  Date of Assessment:    *\*Please attach My Aged Care Support Plan to referral if available* |

**Privacy Notice Latrobe Community Health Service (LCHS) is committed to protecting your personal information. The details provided in this referral form will be used solely to assess eligibility and provide support through the Carer Support Program. Your information will be stored securely and handled in accordance with the** [**LCHS Privacy Policy and**](https://www.lchs.com.au/privacy/) **relevant legislation.**

**For more information, please visit the LCHS Privacy Policy or contact us on 1800 242 696**