**RAHS REFERRAL FORM** **FOR HOME CARE PACKAGE (HCP) / SHORT TERM RESTORATIVE CARE (STRC), COMMONWEALTH HOME SUPPORT PROGRAMME (CHSP) CLIENTS**

1. **HCP / STRC /CHSP CLIENT DETAILS**

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Date of Birth: | Phone: |
| Gender:  Male  Female  Prefer not to say | Email: |
| Address:  Suburb: State: QLD  Postcode: | |
| Alternative or Main Contact:  Name: Phone:  Relationship: Email: | |
| Type of Client:  HCP Level: 1  / Level 2  / Level 3  / Level 4  **(Please select which level)**  CHSP  STRC | |
| Living Arrangement:  Alone  Family/Partner  Supported Accommodation  Other | |

1. **REFERRER DETAILS (JUST INSET YOUR EMAIL SIGNATURE)**

|  |
| --- |
|  |

1. **BACKGROUND**

|  |
| --- |
| **Please provide background information about the client, medical conditions, current situation:**  Please forward a copy of the client’s most recent My aged Care Support Plan, this provides us with the clients Good Equipment and Assistive Technology (GEAT) code (if they have one) and their medical and social background information. Also, if available a Medical Summary from the clients GP.  ☐ My Aged Care Support Plan Attached with this referral  ☐ GP Medical Summary |

|  |  |  |  |
| --- | --- | --- | --- |
| **What would you/ your client like to achieve from this referral?**   |  | | --- | | Full Home Assessment *(The OT will complete an assessment in the client’s home and provide recommendations for any necessary home modifications and equipment to support function in the home and community, please always select this option for CHSP referrals)*  **Please provide details with what the client is experiencing difficulties with:** | | Equipment Only - **Please provide details with what the client is experiencing difficulties with.** | | Home Modifications - **Please provide details with what the client is experiencing difficulties with.** | |

1. **SAFETY**

|  |  |
| --- | --- |
| Are you aware of any occupant at the client premises having an infectious disease? (i.e. covid chicken pox / shingles / gastro, etc.)  If Y – please advise: | Y  N |
| Do you have any pets on the premises that our staff should be aware of?  Details: | Y  N |
| Are there any other factors we should be aware of? If YES, please describe: | Y  N |

1. **PAYMENT OF ACCOUNT / INVOICES**

|  |
| --- |
| Who is responsible for paying the account for Occupational Therapy Services:  **Organisation Name:**  **Name of person responsible for the account:**  **Phone:**  **Email:** |

1. **TO COMPLETE THIS REFERRAL FORM**

Please state your full name and date this referral and return via email the completed form to:

**Email:** [**RAHS@outlook.com.au**](mailto:RAHS@outlook.com.au)

**Referrer’s Name:**

**Date:**

*Following receipt of your referral we will confirm we can schedule in an appointment for your client see our Occupational Therapist. If a current contract/brokerage agreement is not in place between RAHS and your organisation we will be in touch to arrange and discuss rates and completing the necessary paperwork.*