**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 Contact:  Name: Phone:  Relationship: Email: | |
| Type of Client:  HCP Level 1 / Level 2 / Level 3 / Level 4 (Please circle or highlight which level)  CHSP  STRC | |
| Living Arrangement:  Alone  Family/Partner  Supported Accommodation  Other | |

1. **REFERRER DETAILS**

|  |  |
| --- | --- |
| Name of Organisation: | |
| First Name | Last Name: |
| Phone: | Postcode: |
| Email: | |
| Job title: | |

1. **BACKGROUND**

*(Please provide background information about the client, medical conditions, current situation)*

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| **Please advise:** |

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| **What would you/ your client like to achieve from this referral?** |

1. **SAFETY**

*(In order to proceed with your referral ALL questions* ***MUST*** *be ticked.****)***

|  |  |
| --- | --- |
| Is anyone at your / the client’s property, known to be aggressive or violent?  If Y – please advise: | Y  N |
| Does anyone at your/the clients property have a criminal history?  If Y – please advise: | Y  N |
| Is there a history of drugs or alcohol misuse at the property?  If Y – please advise: | Y  N |
| Are you aware of any firearms being stored at the property?  If Y – please advise: | Y  N |
| Are you aware of any occupant having an infectious disease? (i.e. covid chicken pox / shingles / gastro, etc.)  If Y – please advise: | Y  N |
| Do you have any pets at your premises?  Details: | Y  N |
| Are there any other factors we should be aware of? If YES, please describe: | Y  N |

1. **PAYMENT OF ACCOUNT / INVOICES**

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| --- |
| Who is responsible for paying the account for Occupational Therapy Services:  Organisation Name:  Name of person responsible or 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)

**Full 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.*