**My Age Care – Referral  
Home Care Packages/Commonwealth Home Support Program/ Short Term Restorative Care.**

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| --- | --- | --- |
| PROGRAM | Home Care Packages  Commonwealth Support Program  Short Term Restorative Care | |
| SERVICES | Physiotherapy  Exercise Physiology  Occupational Therapy  Psychology | Podiatry  Dietetics  Speech Pathology  Massage Therapy |
| Date of Referral |  | |
| Referral Source | **Self**  **Relative/Friend** | **Media**  **Other** |
| APPOINTMENT TYPE | **Home Visit** | **Clinic Based** |
| PATIENT DETAILS | | | |
| NAME |  | | |
| DATE OF BIRTH |  | | |
| CONTACT PHONE NUMBER |  | | |
| ADDRESS |  | | |
| EMAIL ADDRESS |  | | |
| GENDER |  | | |
| CASE MANAGER DETAILS | | | |
| Case Manager Name |  | | |
| Company Detail |  | | |
| Contact Number |  | | |
| Email Address |  | | |

|  |  |  |
| --- | --- | --- |
| MEDICAL DETAILS | | |
| MEDICAL CONDITION/S |  | |
| TREATING SERVICE & CENTRE |  | |
| OTHER INFO | *Special Needs* |  |
| *Carer’s Details* |  |
| *Additional* |  |
| Detail of Service Requested: |  | |

|  |  |  |
| --- | --- | --- |
| Mandatory documents provided: | | |
| M.A.C | Medical History | Relevant Report |

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| --- |
| OH&S – Home Visits Only – Risk Assessment and Participant Behaviour Management Plan |
| Is there adequate parking available?  YES  NO  Are animals restrained?  N/A  YES  NO  Is there mobile phone reception/signal at the participant home address?  YES  NO  Are there any other access or safety issues to be aware of?  YES  NO  Participant Behaviour Awareness?  YES  NO  If Yes, provide details: |