**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 |  |

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

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| 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 [ ]  NOParticipant Behaviour Awareness? [ ]  YES [ ]  NOIf Yes, provide details: |