Community Care Services

Client Referral

Fax: 8332 6338
Phone: 8366 4611

Date of Referral: ______/_____/_____

Community Care Services provides a range of in-home services and social support programs to assist Home & Community Care (HACC) eligible people to remain living independently in their own homes.

Clients are required to undertake an in home assessment by an assessment officer to ensure the client fulfils our eligibility criteria and to ensure the correct services/referrals meet the individual needs of the client.

Client Information

Title ______ Surname ________________________________ Given Name ______________________

Street Address ____

Suburb __________________________ Postcode ________ Telephone No _____________________

Gender: Male ❑ Female ❑ Date of Birth ______ / _______/ ________ Age ___________

Aboriginal or Torres Strait Islander? Yes ❑ No ❑

Interpreter required Yes ❑ No ❑

Ambulance Cover Yes ❑ No ❑

Emergency Contact Details

Title _____ Surname ________________________________ Given Name _______________________

Home Phone No _____________________________ Mobile No ________________________________

Relationship to Client _________________________________

Relevant Health History

Medical Conditions / Disabilities

____

____

____

____

____

____

City of Norwood Payneham & St Peters
175 The Parade, Norwood SA 5067

Telephone 8366 4555
Facsimile 8332 6338
Email townhall@npsp.sa.gov.au
Website www.npsp.sa.gov.au

City of Norwood Payneham & St Peters

Equipment in place

Walking Frame ❑ Walking Stick ❑ Mobility Scooter ❑

Toilet Raiser ❑ Shower Chair ❑ Hand Rails ❑

Other (specify) ____

Housing

Own Home / Unit ❑ Private Rental ❑ Housing SA ❑ Retirement Village ❑

Other (specify) ____

Lives

Alone ❑ With Spouse/Partner ❑ With family ❑

Other (specify) ____

Current Support Services

RDNS ❑ Domiciliary Care ❑ Meals on Wheels ❑ Mental Health Service ❑

Palliative Care ❑

Other (specify) ____

Has the client been assessed by ACAT? Yes ❑ No ❑

Has a referral been made to ACAT? Yes ❑ No ❑

Regular Doctor Contact Details

Doctors Name ____

Surgery Address ____

Suburb _____________________________ Post Code _______________________

Phone Number ____________________________

Income Source

Aged Pension ❑ Disability Pension ❑ Carer Payment ❑

Self Funded ❑ DVA Gold Card ❑

Other Specify ____

Services Required

Short-term Cleaning ❑ **Details:** ____

____

Long-term Cleaning ❑ **Details:** ____

____

Home Modifications ❑ **Details:** ____

____

Home/Garden Maintenance ❑ **Details:** ____

____

Shopping List ❑ **Details:**____

____

Shopping Transport ❑ **Details:**____

____

Personal Care ❑ **Details:** ____

____

Social Programs ❑ **Details:** ____

____

Referral Source

Discharge Date: ______/_____/_____

Name of referrer: ____

Agency/Hospital ____

Phone ________________________________ Email ________________________________

Has the client agreed to the referral? Yes / No

(if no, identify the reason referral has been made without permission)

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