Community Care
REFERRAL FORM

SEND TO: COMMUNITY CARE

T (08) 8375 6649
F (08) 8375 6699
E community.care@marion.sa.gov.au
Po Box 21 Oaklands Park SA 5046
245 Sturt Road Sturt SA 5047
marion.sa.gov.au

Name……

Address:……

……

Phone:……..…DOB:……/……/…….

Country of Birth……..……..

Primary Language……..

Interpreter needed……Yes/No

Aboriginal/Torres Strait Islander……..Yes/No

Emergency contact ……

Relationship……

Phone……..

DWELLING

□ Home Owner □ Public Rental

□ Private Rental □ Strata Title

□ Ind. Living Unit □ Other……

HOUSEHOLD SUPPORT

□ Alone □ Spouse/Partner

□ Family □ Others

PENSION

□ Aged Pension □ Disability Support

□ DVA Gold □ White □ Carer Pension

□ DVA other…… □ Carer Allowance

□ Compensation □ Self funded/Super

□ Other ……..

Person is a Carer…….Yes/No Person has a Carer……Yes/No

Carer/ee Co-Resident……..Yes/No

Carer/ee Name..……..

Relationship ……

DOB……..……Sex……Male / Female

Address……

……..

Phone……..

Is the carer the contact person……..Yes/No

Caring for more than 1 client……..Yes/No

REFERRAL DETAILS

□ Ashford Hospital □ Flinders Medical Centre

□ Glenelg Hospital □ Griffiths Rehabilitation Hospital

□ Noarlunga Hospital □ Repatriation Hospital

□ Other ……...

Has a referral been made to My Aged Care?...Yes/No

My Aged Care number: **AC**……..

REFERRER:..……..……

PHONE:……..DATE:..…../……/…….

Referral Date……/……/…….Discharged..…../…../…….

Date of Assessment……../……../……..

Assessed by ……..……..

Has the Client given their permission for this referral……Yes/No

REFERRAL REQUEST……

……..

……..

……..

……..

□ Attached: □ Modification diagram/s

□ Handrails – Home pre 2000? Yes/No

□ Health Summary

□ Care Plan

CURRENT AGENCY SUPPORT:

..……

Is the person in receipt of a Package or Transitional Care Package?…….....Yes/No

……..

Name of Provider of package……..

Level of Package……....

Reasons for support (Please specify any health issues and / or risk factors)…….

……..

……

WHS/HOME ACCESS

Issues / Risks……

Please attach any additional relevant information