



COMPREHENSIVE INFORMATION SHEET

REGISTRATION FORM

Date	Carer Details	1800 Yes <input type="checkbox"/> No <input type="checkbox"/>
Carer's Name	DOB	
Address		
Phone (02)		
Are you a live in carer Yes <input type="checkbox"/> No <input type="checkbox"/> Relationship to person caring for:		
No of people caring for:	Verbal consent for referral	Yes <input type="checkbox"/> No <input type="checkbox"/>
Country of Birth	Aboriginal Yes <input type="checkbox"/> No <input type="checkbox"/>	
Language spoken at Home	Interpreter Yes <input type="checkbox"/> No <input type="checkbox"/>	
Income source		
Pension - Full <input type="checkbox"/> Part <input type="checkbox"/> Nil <input type="checkbox"/>	Carer Allowance Recipient <input type="checkbox"/>	
Carer Payment <input type="checkbox"/> Employed - Part-time <input type="checkbox"/> Fulltime <input type="checkbox"/> Other <input type="checkbox"/>		
Pension – DVA <input type="checkbox"/> Number _____	Gold <input type="checkbox"/> White <input type="checkbox"/>	
Length of time as a carer		
Less than 1yr <input type="checkbox"/>	3 – 5yrs <input type="checkbox"/>	5 – 10yrs <input type="checkbox"/> More than 10yrs <input type="checkbox"/>
Date commenced:		
Caring Role		
Carer's Health (physical and emotional impacts on caring role)		
What are your other responsibilities (work/domestic/family/relationship)		

Carer's Goals: *(for themselves and person they care for)*

What effect is your caring role having on you and your family *(capacity to continue)*

What support do you get from family/friends

What would assist you in your caring role

What is the state of the relationship with the person for whom you care

Current pattern of responsibilities and time commitments

What are the sleep impacts in your caring role

What is the financial impact of your caring role

Social impacts of caring role

What are your information and education needs