SOUTHERN HIGHLANDS CARER RESPITE CENTRE
CARER PROFILE

Date: / / Client Id: EMERGENCY YES/NO

REFERAL SOURCE

Name: Contact Number:

Organisation:

How did you find out about our service?

CARER DETAILS

Carer's Name:

Address/Street:

Address/Postal (if different):

Phone: (h) (w) Date of Birth: / / Age:

Country of Birth: Aboriginal/TS Islander Yes ❑ No ❑

Language spoken at home: Interpreter Yes ❑ No ❑

INCOME SOURCE

Disability Support Pension ❑ Carer Allowance ❑ Carer Payment ❑

Full Pension ❑ Part Pension ❑ No Pension ❑ Full Time Employed ❑

Part-time Employment ❑ Other ❑

RELATIONSHIP OF CARER TO CARE RECIPIENT

Spouse ❑ Parent ❑ Child ❑ Other relative ❑ Friend/neighbour ❑

LENGTH OF TIME AS CARER

Less than 1yr ❑ 3-5yrs ❑ 5-10yr ❑ More than 10yrs ❑

ALTERNATE CARER DETAILS

Name: Address: Postcode:

Phone: Relationship to Care Recipient:

RESPITE SERVICES CURRENTLY BEING USED

Homecare: ❑ Community Options: ❑ Interchange: ❑ Daycare: ❑

Community Transport: ❑ Meals on Wheels: ❑ Dementia Program: ❑

Home Living Support: ❑ Other services: ❑

Comments:

PERSON TO RECIEVE CARE

Name: Date of Birth: / / Age:

Address:

Phone:

Country of Birth: Aboriginal/TS Islander Yes ❑ No ❑

Language spoken at home:

Department of Veterans' Affairs Status: GOLD ❑ WHITE ❑ Number:

GENERAL PRACTITIONER

Doctor: Phone:

Address:

INCOME SOURCE

Disability Support Pension ❑ Carer Allowance ❑ Carer Payment ❑

Full Pension ❑ Part Pension ❑ No Pension ❑ Full Time Employed ❑

Part-time Employment ❑ Other ❑

CLIENT CATEGORY
Frail Aged ❑ Chronic illness ❑ More than one Care Recipient ❑
Younger person with a disability ❑
FACS DISABILITY CATEGORY
Aged ❑ Developmental delay (child under 6yrs)❑Intellectual ❑Specific learning/ADD ❑
Physical ❑ Acquired Brain Injury ❑ Autism (incl. Asperger's Syndrome) ❑
Vision ❑ Hearing ❑ Speech ❑ Psychiatric ❑ Neurological ❑ Dual Sensory ❑
DOES THE PERSON REQUIRE SUPPORT WITH:
Personal Care - Sometimes ❑ Always ❑Comments:
Mobility -Yes ❑ No ❑ Equipment used:
Communication –Verbal ❑ Non-verbal ❑
Food Preparation: Yes ❑ No ❑ Eating a meal: Yes ❑ No ❑
Assistance with medications: Yes ❑ No ❑
Comments:
MEDICAL SITUATION-INFORMATION ON DISABILITY
Medical information:
Medications:
Challenging behaviours: Yes ❑ No ❑
Comments:
RESPITE REQUEST
BROKERAGE DETAILS – PURCHASE OF SERVICE
Service Provider: FACS ❑ CRC ❑
Dates:
Times:
Quote/Agreed Costs:
Referral to other Services providers:
INFORMATION-ADVICE
Carer Payment/Allowance Package ❑ SHCRC Brochure ❑Other information ❑
Comments:
CONSENTS FOR REFERRALTO SERVICES AND FUNDING BODIES
Consent given for this referral Yes ❑ No ❑
Consent given for further referral to services & funding bodies Yes ❑ No ❑