

Far North Coast Carer Respite Centre

CARER PROFILE

Only to be completed when carer has given consent

Date	Client Number

CARER INFORMATION

Title	Full Name	Prefers to be called

Usual Address		Telephone Number
No	Street	Home:
Suburb	P/Code:	Work:
		Mobile:

Current Address (if different)		Telephone Number
No	Street	
Suburb	P/Code:	

GENDER: Female Male

AGE: DATE OF BIRTH: ____/____/____

Country of birth	Ethnicity	Language spoken at home

Communication assistance required? Yes No Specify

Identifies as Aboriginal/Torres Strait Islander **LIVING WITH CARE RECIPIENT** Yes No

How did Carer hear about CRC?	Carers Relationship to Care Recipient

Source of Referral

Name

Case Manager YES NO

Organisation

Contact No

Reason for referral and/or type(s) of assistance being sought

Caring for a Person with:

- Chronic / Terminal Illness
- Younger person with Disability
- Frail Aged
- Caring for more than one person

SELF CARER

Primary Income	Carer	Type	Care Recipient	Type
Full Pension	<input type="checkbox"/>		<input type="checkbox"/>	
Part Pension	<input type="checkbox"/>		<input type="checkbox"/>	
No Pension	<input type="checkbox"/>		<input type="checkbox"/>	
P/T Employment	<input type="checkbox"/>		<input type="checkbox"/>	
F/T Employment	<input type="checkbox"/>		<input type="checkbox"/>	

DVA

DVA Carer <input type="checkbox"/>	DVA Pension No.	DVA Type
DVA Recipient <input type="checkbox"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Assessed by ACAT Low High Date of assessment

Assessed by _____

CARING COMMENCED: ____/____/____

Services Currently In Use/Or Used Regularly		
Service Type	Provider Organisation	Frequency of Respite Days & hrs per week/fortnight/month
Personal Care		
Cleaning/Housework		
Centre Based/Residential Respite		
Food Services		
Packages		Type:
Other		

Outline of Care Responsibilities	Carer's Time Spent Caring
<p>Receiving Carer Allowance <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Less than 21 hrs per week <input type="checkbox"/></p> <p>21 to 49 hrs per week <input type="checkbox"/></p> <p>50 hrs or more per week <input type="checkbox"/></p>

**OTHER CARING RESPONSIBILITIES:
EG OTHER CHILDREN, PARTNER ETC.**

Informal Support				
Provided by (Relationship to Care Recipient)	Daily (Hours)	Wkly (Days)	Other (Specify)	Outline of Assistance

What Does the Carer Need on this Occasion?

DISABILITY TYPE/ILLNESSES

Details Collected by _____