2ND CONTACT IN CASE OF EMERGENCY

Title | Full Name | Telephone

Address

Hm: _____
Wk: _____
Mobile: _____

Relationship to Carer: _____

PERSON BEING CARED FOR INFORMATION

Title | **First Name** | **Last Name**

Usual Address

Street
Town Postcode

Telephone No.

Gender: Female ☐ Male ☐

Age: Date of Birth

RELATIONSHIP TO CARER:

Country of birth | **Ethnicity** | **Language spoken at home**

Communication assistance required? Yes | No If Yes, Specify

Identifies as Aboriginal/Torres Straight Islander? Yes | No **Ambulance Subscriber** Yes | No

Medical Practitioner

Name: _____

Telephone: _____

CARE RECIPIENT'S NEED

- ☐ **High** (Practical assistance with most ADL's, mobility and communication)
- ☐ **High** (As above plus additional factors)
- ☐ **Moderate** (no additional factors)
- ☐ **Moderate** (plus additional factors)
- ☐ **Low** (no additional factors)
- ☐ **Low (**plus additional factors**)**

6.

DISABILITY DETAILS

TICK ONE ONLY:

Developmental delay (>6yrs)	Vision
Intellectual	Hearing
Specific learning/ADD/ADHD	Speech
Physical	Psychiatric
Acquired Brain Injury	Neurological
Autism (incl.Asperger's Synd)	Dementia
Deaf/Blind(dual Sensory)	Aged
Other (please specify)	

CASE MANAGEMENT:

Name of Case Manager: _____ Telephone: _____

Organisation Name: _____

OTHER RECIPIENT INFORMATION

CARE ISSUES

ISSUE	COMMENTS
Incontinent	
Wandering	
Nursing	
Behavioural Problems	
Emotional Dependence	
Disturbed Sleep	
24 Hour Care Required	
Other	

ACTIVITIES OF DAILY LIVING (Status: I-Independent, A-With Assistance, D-Dependant)

ADL	STATUS	COMMENTS
Hygiene		
Mobility		
Medication		
Home		
Toilet		
Meals		
Other		

OTHER ISSUES RELEVANT TO RESPITE including hazards for in-house respite

Is there a dog on the premises? **Yes** ☐ **No** ☐

Does the client smoke? **Yes** ☐ **No** ☐

Any other identified hazards? _____

_____

Verbal consent given to pass relevant information on:

Date _____ **Signed** _____

CO-ORDINATOR NAME: _____