



Inner West Carer Respite Centre
Client Information and Referral Record

Phone:

9767 7972

Fax:

9767 5042

Date: _____

Id Number: _____

Carer Profile

Carer Name: _____

Address: _____

Phone: _____ DOB: _____ Sex : Male Female

Country of Birth: _____ Language Spoken: _____

Interpreter Required: Yes No

Does the Carer self-identify as an Aboriginal or Torres Strait Islander ? Yes No

Please note: any cultural, religious or language barriers or if an ethno-specific worker is required:

Has this carer, responsibilities to more than one frail aged, disabled or chronically ill person? Yes No

Length of time as carer?(please circle) >1 1 – 3yrs 3 – 5 yrs 5 – 10yrs 10 +

Carer Financial Situation

- Full Pension Part Pension No Pension
- P/T Employed F/T Employed DVA
- Carer Allowance Carer Payment

Reason For Referral: _____

Please Tick	Emergency	Non Emergency
Business Hours		
After Hours		

Service and Care Required: _____

Dates and Times of Service: _____

Referred By: _____

Relationship/Position: _____

Address: _____ Phone: _____

Person cared for: _____

Address: _____

Phone: _____ DOB: _____ Sex: Male Female

Relationship to Carer: _____

Country of Birth: _____ Language Spoken: _____

Interpreter Required: Yes No

Does the person cared for self-identify as an Aboriginal or Torres Strait Islander? Yes No

Person cared for - Financial Situation

Full Pension Part Pension No Pension

P/T Employed F/T Employed DVA

Local Doctor: _____ Phone: _____

Medical History/ Diagnosis: _____

Category of person cared for:

Younger Disabled Frail Aged Dementia

Chronic Illness Carer of more than one DVA

Community Supports

Home Care MOW Comm. Options

ACST/ ACAT or DOC's: known to: _____

SHNS Com Care Package Mental Health Team

Regal Health Day Hospital Priv. Cleaning

Comm. Transport Day Care* Respite*

* List Service provider, days and times: _____

Office use only:
Approved / Not Approved by CRC Manager/Authorised Service Contractor:
Signed by CRC Manager, Delegated Staff Member or Service Contractor
Signature: _____
Date: _____
Service Type: (1 to 16) _____
Follow up required: 1/52 2/52 3/52 1/12 2/12
Comments: _____
