Queensland Government

METRO SOUTH HEALTH

Community Adult Rehabilitation Service (CARS)

Referral Form

Facility: _____

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Phone: 1300 364 155 Fax (07) 3156 4382

CLIENT DETAILS

Client Address: _____

Suburb: _____ **Postcode:** _____

Home Phone: ( ) **Work Phone:** ( ) **Mobile:**

Country of birth: ☐ Australia ☐ Other - Specify: _____

Interpreter required? ☐ No ☐ Yes - Language: _____

Marital Status: Specify: _____

Does the client identify with being Aboriginal and/or Torres Strait Islander, or Australian South Sea Islander (ASSI)?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both ☐ Yes, ASSI

Client's GP: _____ **Practice Fax:** (__)_____

Practice Name: _____ **Practice Phone:** (__)_____

MEDICARE NUMBER: ____/____/_____ **Expiry Date:** _____

Client Card Details

Does the client have:

Pension card? ☐ No ☐ Yes - **Type:** ☐ Aged ☐ Disability ☐ Other:
Card Number: ***Expiry:***

DVA? ☐ No ☐ Yes - **Type:** ☐ White ☐ Gold ☐ Other
Card Number: ***Expiry:***

Private Health Insurance? ☐ No ☐ Yes **- Details:**

Work Cover? ☐ No ☐ Yes **- Details:**

EMERGENCY DETAILS / NEXT OF KIN

☐ Next of Kin Only ☐ Emergency Contact Only ☐ Both

Family Name: _____ Home phone number: ( )_____

Given Name: _____ Work phone number: ( )_____

Relationship to client: _____ Mobile: _____

REFERRAL TO COMMUNITY ADULT REHABILITATION SERVICE (Please tick all relevant)

Reason for Referral:	☐ Medically Stable ☐ Recent discharge from a rehab unit ☐ History of multiple falls ☐ Diagnosis of stroke, Parkinson's disease, other progressive neurological ☐ De-conditioning / other _____	Logan Beaudesert Service Only ☐ Dietician ☐ Speech Pathology- Swallow, Dysphagia
Current Allied Health Involvement:	☐ Occupational Therapy ☐ Physiotherapy ☐ Social Work	☐ Dietician ☐ Speech Pathology ☐ Other – **Specify:** _____

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Recommended Allied Health Input	All Sites- Rehab Referrals	Logan Beaudesert Service Only
	☐ Occupational Therapy ☐ Physiotherapy ☐ Social Work ☐ Speech Pathology	☐ Dietician ☐ Speech Pathology- swallow, dysphagia

CURRENT HEALTH HISTORY AND REASON FOR REFERRAL

Please attach any relevant reports and include health history / current and previous levels of function/ mobility status / medications list/ identify achievable client goals

S

B

A

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OTHER SERVICES INVOLVED/ REFERRALS

Other services involved? ☐ Yes ☐ No ☐ Referral made

Name of service/s? (e.g NGO involvement/ ACAT/ current level of care)

Services currently received/ requested:

OTHER HEALTH DETAILS

Does the client have:

☐ Enduring Power of Attorney ☐ Capacity to make decisions ☐ Learning difficulties

LIVING SITUATION

What is the current living situation?

☐ Lives alone ☐ Lives with partner ☐ Lives with other – **Specify:**

☐ Own home ☐ Private rental ☐ Retirement village

☐ Supported Accommodation ☐ Public Rental ☐ Other – **Specify:**

Are you aware of any risks to the safety of home visiting staff?

☐ No ☐ Yes – **Specify:**

REFERRAL SOURCE (Please print clearly)

Name:		Profession/Role:
Workplace:		
Address:		
Phone: ( )	Phone: ( )	Feedback required? ☐ No ☐ Yes

SIGNATURE: Date:

PLEASE FAX TO Referral Service 3156 4382

Email: metrosouth_communityreferral@health.qld.gov.au

DO NOT WRITE IN THIS BINDING MARGIN