

Health Professional Referral Form

Referral Date: ____ / ____ / ____

About This Form

If you need assistance to apply for or increase your My Aged Care services, Care U Home Care can support you throughout the process.

We can help understand your mobility and daily living needs, guide you in providing relevant medical information, and, with your consent, assist with communication with the relevant assessment organisation and the arrangement and support of a home visit assessment.

Please provide as much information as possible. Any information that is currently unavailable can be left blank.

INFORMATION CHECK

- ☐ Client details completed
- ☐ Family contact provided
- ☐ Medical information provided
- ☐ Functional needs identified
- ☐ Consent obtained

01 CLIENT INFORMATION

Full Name					Date of Birth		
Residential Address							
Phone Number							
Email Address							
Medicare Number							Position Number

02 FAMILY CONTACT

If you have a child, family member or another person who can assist you, please provide their details below.

Name			Relationship to Client	
Phone Number				
Email Address				
Preferred Contact:	☐ Yes	☐ No		

03 CLIENT MEDICAL CONDITION

Main / Urgent Medical Conditions

Please provide information about the client's main or urgent medical conditions and how these conditions affect their safety, mobility, independence or ability to manage daily activities.

Medical Information:

Quick Check

Please tick any that currently apply:

- | | | |
|--|--|---|
| ☐ Mobility difficulties | ☐ Needs physical assistance | ☐ Recent hospitalisation |
| ☐ Falls | ☐ Memory concerns | ☐ Recent surgery |
| ☐ Uses walking aid | ☐ Vision difficulties | ☐ Other |
| ☐ Needs supervision | ☐ Hearing difficulties | |

CARE U HOME CARE

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04 DAILY LIVING & FUNCTIONAL NEEDS

Please tick any areas where the client currently requires assistance or experiences difficulty.

- | | |
|---|---|
| ☐ Showering | ☐ Shopping |
| ☐ Dressing | ☐ Transport |
| ☐ Toileting | ☐ Mobility |
| ☐ Personal Care | ☐ Falls Risk |
| ☐ Meal Preparation | ☐ Memory / Cognition |
| ☐ Domestic Tasks | ☐ Vision / Hearing |
| Other: _____ | |

Additional Information: _____

05 AGED CARE PATHWAY & SUPPORT STATUS

Please complete the following checklist based on the information currently available to you.

1. TRANSITION CARE PROGRAM (TCP)

Is the client currently receiving or being considered for the Transition Care Program (TCP)?

- | | |
|--|--|
| ☐ Currently receiving TCP | ☐ Approved / eligible |
| ☐ Assessment pending | ☐ Referral being considered |
| ☐ Not applicable | ☐ Unknown |

2. CARE GATEWAY / CARER SUPPORT

Does the client currently have Care Gateway / carer support involvement?

- | | |
|--|--|
| ☐ Already connected | ☐ Referral made / recommended |
| ☐ Not currently connected | ☐ Not required / not applicable |
| ☐ Unknown | |

3. CHSP – COMMONWEALTH HOME SUPPORT PROGRAM

Has the client applied for CHSP?

- | | |
|--|---|
| ☐ Yes – applied | ☐ No – not applied |
| ☐ Currently receiving CHSP services | ☐ Unknown |

4. RESTORATIVE CARE PATHWAY (RCP)

Is the Restorative Care Pathway (RCP) required or should it be considered?

- | | |
|---|---|
| ☐ Required / likely to benefit | ☐ Recommended for further assessment |
| ☐ Not currently required | ☐ Unknown |

RCP suitability and access are subject to the relevant aged care assessment and eligibility requirements.

ADDITIONAL PATHWAY INFORMATION

06 OTHER IMPORTANT INFORMATION

For example, recent hospitalisation, surgery, falls, discharge from hospital, significant changes in health, or assessments/reports currently being arranged.

Other Important Information: _____

07 REFERRAL INFORMATION

Referring Organisation

Referrer Name

Contact Number

Referral Date

Reason for Referral

08 CLIENT CONSENT & SIGNATURE

I confirm that the information provided above has been provided with my knowledge and consent. I agree that Care U Home Care may use this information to assist with application support, assessment and relevant home care services, and communicate with relevant organisations where required.

Client / Applicant Signature _____ Date ____ / ____ / ____

CARE U HOME CARE

医疗及健康专业人员转介表



转介日期： ____ / ____ / ____

申请协助说明

如果您需要申请或升级 My Aged Care 服务，我们可以协助您完成相关流程。

我们会根据您的实际情况，了解您的行动能力和日常生活需要，并指导您准备和收集相关医疗资料。在您同意的情况下，我们也可以协助与相关评估机构沟通，并协助安排、准备和配合家访评估。

请尽可能填写以下信息。如有暂时无法提供的内容，可以留空。

信息检查

- ☐ 客人基本信息已填写
- ☐ 家属联系方式已填写
- ☐ 医疗情况已填写
- ☐ 日常生活需求已了解
- ☐ 已取得客人同意

01 客人基本信息

姓名				出生日期			
住址							
联系电话				邮箱			
Medicare号码					Position号码		

02 子女 / 家属联系方式

如果您有子女、家属或其他可以协助您的联系人，请填写以下信息。

姓名				与客人关系			
联系电话				邮箱			
首选联系人：	☐ 是 ☐ 否						

03 目前主要医疗情况

主要 / 紧急的医疗状况

请填写客人目前主要或需要特别关注的医疗情况，以及这些情况对其安全、行动能力、独立生活能力或日常活动造成的影响。

医疗情况：

常见情况

请勾选目前适用的情况：

- ☐ 行走困难
- ☐ 容易跌倒
- ☐ 使用助行器
- ☐ 需要陪护监督
- ☐ 需要身体协助
- ☐ 记忆力问题
- ☐ 视力问题
- ☐ 听力问题
- ☐ 其他
- ☐ 近期住院
- ☐ 近期手术

04 日常生活及功能需求

请勾选客人目前需要帮助或存在困难的方面。

- ☐ 洗澡
- ☐ 穿衣
- ☐ 如厕
- ☐ 个人护理
- ☐ 做饭
- ☐ 家务
- 其他：_____

- ☐ 购物
- ☐ 外出及交通
- ☐ 行动
- ☐ 跌倒风险
- ☐ 记忆或认知
- ☐ 视力或听力

补充说明：

05 养老服务项目 / 支持项目状态

请医疗及健康专业人员根据目前掌握的信息勾选。

1. TRANSITION CARE PROGRAM (TCP) — 过渡护理计划

客人目前是否正在接受或正在考虑 Transition Care Program (TCP) ?

- ☐ 目前正在接受 TCP
- ☐ 正在等待评估
- ☐ 不适用

- ☐ 已获批准 / 符合资格
- ☐ 正在考虑转介
- ☐ 不清楚

2. CARE GATEWAY / CARER SUPPORT

客人目前是否已经有 Care Gateway / 照顾者支持 ?

- ☐ 已经取得联系 / 正在接受相关支持
- ☐ 目前没有相关支持
- ☐ 不清楚

- ☐ 已转介 / 建议转介
- ☐ 不需要 / 不适用

3. CHSP — 老年人社区家庭支持计划

客人是否已经申请 CHSP ?

- ☐ 是 — 已申请
- ☐ 目前正在接受 CHSP 服务

- ☐ 否 — 尚未申请
- ☐ 不清楚

4. RESTORATIVE CARE PATHWAY (RCP) — 恢复性护理路径

客人是否需要 RCP, 或是否建议进一步考虑 RCP ?

- ☐ 需要 / 可能适合
- ☐ 目前不需要

- ☐ 建议进一步评估
- ☐ 不清楚

RCP 是否适合以及是否能够获得相关服务, 需要根据相关养老评估及资格要求确定。

其他养老服务 / 项目信息

06 其他重要情况

例如近期住院、手术、跌倒、出院、身体状况明显变化, 或目前正在安排的评估 / 报告。

其他重要情况：

07 转介信息

转介机构

转介人员姓名

联系电话

转介日期

转介原因

08 客人同意及签名

本人确认以上信息是在本人知情和同意的情况下提供, 并同意 Care U Home Care 在提供申请协助、评估及相关居家支持服务的过程中使用这些信息, 并在需要时与相关服务机构进行沟通。

客人 / 申请人签名

日期 ___ / ___ / ___