

Consumer Information

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

Consumer Details

Family Name: _____

Given Names: _____

Date of Birth *dd/mm/yyyy* / /

Preferred Name/s: _____

Sex (*circle one*) Male Female

Title (*circle one*) Mr Mrs Ms Other

Contact Details

Contact Address (*for correspondence, home visits etc*)

_____ (*number*) _____ (*street*)

_____ (*suburb/locality*) _____ (*postcode*)

Usual Address: (if different from contact address)

_____ (*number*) _____ (*street*)

_____ (*suburb/locality*) _____ (*postcode*)

Contact Phone Number/s (*tick preferred number*) Can leave message? Y or N

Home: _____

Work: _____

Mobile: _____

Fax: _____

Email: _____

Who the Agency Can Contact if Necessary (*eg, case manager, next of kin, carer, guardian, friend, emergency contact*)

Person 1 Name: _____

Contact Details:

_____ (*number*) _____ (*street*)

_____ (*suburb/locality*) _____ (*postcode*)

Phone: _____

Relationship to Client: _____

Person 2 Name: _____

Contact Details:

_____ (*number*) _____ (*street*)

_____ (*suburb/locality*) _____ (*postcode*)

Phone: _____

Relationship to Client: _____

General Practitioner (*if no GP, write NA*)

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

This Page Completed By: (*tick one*)

- The consumer or someone who represents the consumer (carer, parent or guardian)
- The agency (face-to-face with consumer)
- The agency (other, incl. telephone contact with consumer)

Consumer privacy information brochure provided? Yes No

Department of Human Services

1620402B



Office Use Only

Name: _____ Designation/Agency: _____

Sign: _____ Date: _____ Contact number: _____

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded
Date: _____ Name: _____ Sign: _____

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Service Requested

Notes: (including alerts and comments on risks, urgency and access issues)

Source of Referral

- Record: (1) Self. (2) Family, significant other, friend.
(3) GP/medical practitioner (community-based).
(4) Specialist aged or disability assess. team/service (eg. ACAT).
(5) Comprehensive HACC assessment authority.
(6) Community nursing service. (7) Hospital (public).
(8) Psychiatric/mental health service or facility.
(9) Extended care/rehabilitation facility. (10) Palliative care facility/hospice.
(11) Government residential aged care facility.
(12) Aboriginal health service. (13) Carelink centre.
(14) Other community-based government medical/health service.
(15) Other government medical/health service.
(16) Other government community-based services agency.
(17) Hospital (private). (18) Non-government residential aged care facility.
(19) Other non-government medical/health service.
(20) Other non-government community-based service.
(21) Law enforcement agency.
(22) Other.

Source of Referral Contact Details:

Country of Birth

Record: (1) Australia. (2) Other.

If other, specify:

Indigenous Status

- Record: (1) Aboriginal but not Torres Strait Islander origin.
(2) Torres Strait Islander but not Aboriginal origin.
(3) Both Aboriginal and Torres Strait islander origin.
(4) Neither Aboriginal nor Torres Strait Islander origin.

Main Language Spoken at Home

Record: (1) English.
(2) Other.

If other, specify:

Interpreter Required

Record: (1) Interpreter not needed.
(2) Interpreter needed.

Preferred language

(if not spoken English), including sign language, and any required communication devices or special interpreter needs:

Government Pensioner/ Benefit Status

- Record: (1) Aged Pension.
(2) Veterans' Affairs Pension.
(3) Disability Support Pension.
(4) Carer Payment (pension).
(5) Unemployment-related benefits.
(6) Other gov. pension or benefit.
(7) No gov. pension or benefit.

Card Number:

DVA Card Status

- Record: (1) No DVA Card.
(2) Yes Gold Card.
(3) Yes White Card.
(4) Yes Other DVA Card.

DVA Card Number:

Insurance Status

Insurer Name and Card Number:

Medicare Number:

Health Care Card Number:

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Name:

Designation/Agency:

Sign:

Date:

Contact number:

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