Compassionate Hearts on the Bellarine
ABN 59 657 570 014

REFERRAL FORM – To be completed for Compassionate Hearts on the Bellarine

Client Details			
Mr/Mrs/Miss/Ms/Other			
Name:			
Address:			
Suburb:			
Postcode:		Phone No:	
Date of Birth:	/ /	Age:	
Does the client live alone?	Yes ☐ No ☐	Comment/s:	
Does the client have pets?	Yes ☐ No ☐	Comment/s:	
Any known risks identified in the home?	Yes ☐ No ☐	If **YES** please state risks	

Primary Contact			
Name:		Relationship:	
Phone No:		Mobile:	

Secondary Contact (in the case of an emergency)			
Name:		Relationship:	
Phone No:		Mobile:	

Referrer Details				
Date of Referral:	/ /			
Referred by:		Tel No:		
Position of Referrer:		Referrer email address:		
Referral urgency:	Low ☐	Medium ☐	High ☐	
Duration of service needed:	Short term ☐ (up to 3 months)	Long term ☐ (more than 3 months)		

GP Details			
GP Practice:		Phone No:	
GP Name:			

Prognosis Information

If you have relevant information about this person's prognosis, expectations and have their consent to share medical information, please include any relevant prognosis details below

Please provide general information (e.g. short term memory loss, disability, general level of wellbeing, mobility, any limitations, aids used etc)

Sensory impairment/s (Please provide details such as difficulties with hearing and/or sight)

Reason for Referral:

PLEASE NOTE: Compassionate Hearts on the Bellarine is a service in addition to ongoing care support that may already be in place prior to this referral. Compassionate Hearts on the Bellarine is a voluntary service and should not be put in place to replace an existing service. It does not provide nursing care or personal care.

The aim in referring this client to Compassionate Hearts on the Bellarine is to:

Referral Type:

- ☐ Help with pets (feeding/walking)
- ☐ Collecting prescriptions
- ☐ Socialisation / Companionship
- ☐ Respite whilst a family member takes a break
- ☐ Life Story writing / Legacy
- ☐ Hand and/or Foot massage
- ☐ Light errands
- ☐ Transportation to hospital / medical appointments / shopping etc
- ☐ Assistance to write letters / non-legal forms
- ☐ Preparing/cooking meals
- ☐ Grief/bereavement support
- ☐ Music making
- ☐ Other - Please specify _____

Record of Client Consent

☐ **Written Client Consent**
The referrer has discussed with me how and why certain information about me may be shared with Compassionate Hearts on the Bellarine. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given

Or

☐ **Verbal Client Consent**
I understand the need to shre the information about me in this referral document with Compassionate Hearts on the Bellarine, and consent to this information being shared and discussed with them.

Or

☐ **Consumer does not have the capacity to provide consent and authorised representative.**
(Name of authorised representative)

I consent to my information being share with Compassionate Hearts on the Bellarine for the purposes of referral:
Yes ☐ **No** ☐

Signature of Client/ Authorised representative		**Date:**	**/ /**
Signature of Referrer:		**Date:**	**/ /**

Date received by CHoB:	/ /	**CHoB Ref No:**	

Referral Outcome

Referral Accepted	☐ Yes		
Referral Rejected Reason for not accepting	☐ No available volunteer ☐ Role not within CHoB scope ☐		
CHoB representative name:			
CHoB representative signature:		Date:	/ /