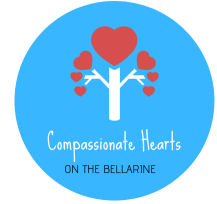




**REFERRAL FORM – To be completed for Compassionate Hearts on the Bellarine**

Client Details			
Mr/Mrs/Miss/Ms/Other			
Name:			
Address:			
Suburb:			
Postcode:		Phone No:	
Date of Birth:	/	/	Age:
Does the client live alone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comment/s:
Does the client have pets?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comment/s:
Any known risks identified in the home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If <b>YES</b> 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 <input type="checkbox"/>	Medium <input type="checkbox"/>	High <input type="checkbox"/>
Duration of service needed:	Short term <input type="checkbox"/> (up to 3 months)		Long term <input type="checkbox"/> (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:

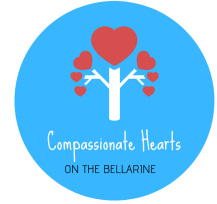
**PLEASE NOTE:** Compassionate Hearts on the Bellarine is a service in addition to ongoing care support that may already be in place prior to this referral. Compassionate Hearts on the Bellarine is a voluntary service and should not be put in place to replace an existing service. It does not provide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

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

*(This area is currently blank, overlaid with a large, faint watermark reading 'DRAFT').*

### Referral Type:

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



### 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 share 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:	
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### Referral Outcome

Referral Accepted	<input type="checkbox"/> Yes		
Referral Rejected	<input type="checkbox"/> No available volunteer <input type="checkbox"/> Role not within CHoB scope		
Reason for not accepting	<input type="checkbox"/>		
CHoB representative name:			
CHoB representative signature:		Date:	/ /