CLIENT REFERAL / DETAILS FORM

The Hospital Research Foundation Group Parkinson's

The Hospital Research Foundation Group Stroke

Has the client given consent to complete this form with their information? ☐ Yes ☐ No if no, please gain consent prior to completing.			
Form completed by:		**Date:**	
Relationship to the Client:			
How did you hear about us?			
Reason for Referral:			
Referral Discipline:			
☐ OT ☐ Nurse ☐ Counselling ☐ Wellbeing		☐ Social Worker ☐ Developmental Educator ☐ Psychologist ☐ Continence Clinic	
Referrer Contact: (skip if GP/Specialist) ☐ Self Referred			
First Name:		Surname:	
Profession/Relationship:		Phone:	
Client Personal Details:			
First Name:		Surname:	
Preferred Name:		Date of Birth:	
Gender Identity:	☐ Male ☐ Female ☐ Non-binary ☐ Other:		
Phone:			
Email Address:			
Home Address:			
Postal Address	☐ As above		
Do you identify as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Prefer Not to Say		
Country of Birth:		Cultural Identity:	
Language Spoken:		Interpreter Required:	☐ Yes ☐ No
Do you have any religious or spiritual beliefs / requirements you would like us to be aware of?:			
Living Arrangements:	☐ Lives alone ☐ Lives with family ☐ Lives with others ☐ Prefer Not to Say		
Accommodation Setting:	☐ Private Residence (owned) ☐ Private Rental ☐ Public Rental ☐ Aged Care Home ☐ Retirement Village ☐ Other:		
Carer Details			
Do you have someone who supports you and acts as a Primary Support Person? ☐ Yes ☐ No			
Carer Name:			
Carer Phone Number:			
Relationship:			
Email Address:			
Do you give consent for us to share information with carer? ☐ Yes ☐ No			
Is the above Carer your Emergency Contact? ☐ Yes ☐ No (if no, please complete emergency contact below)			
Emergency Contact Name:			
Emergency Contact Number:		Relationship:	

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Medical Details				
What is your diagnosis:	☐ Parkinson's ☐ Stroke ☐ Essential tremor ☐ Progressive Supranuclear Palsy (PSP) ☐ Multiple System Atrophy (MSA)		☐ Dementia ☐ Dystonia ☐ Corticobasal Degeneration ☐ Carer/Support Person (nil diagnosis) ☐ Other:	
Year of Diagnosis:				
Medicare Number:		Individual Reference:		
Private Health Provider:		Private Health No:		
GP Details				
GP Clinic Name:				
Phone Number:		Fax Number:		
GP/Clinic Address:				
Do you see: ☐ Neurologist ☐ Geriatrician (if yes, complete below)				
Specialist Name:		Phone number:		
Clinic Address:				
Funding Details				
What best describes your primary source of funding: ☐ Pension ☐ Disability ☐ Carer Payment ☐ Jobseeker/Newstart ☐ DVA Gold ☐ DVA White ☐ DVA Other ☐ Self-Funded ☐ Other:				
NDIS				
Do you receive NDIS funding? ☐ Yes ☐ No		NDIS Number:		
Local Area Coordinator (LAC) email:				
Are you: ☐ Plan Managed: ☐ NDIA Managed ☐ Self-Managed				
Invoice Email:				
AGED CARE				
Do you receive My Aged Care Funding? ☐ CHSP Allied Health Referral Code: ☐ Home Care Package Provider:				
HCP Coordinator Name and email:				
AC Number:		Awaiting Assessment: ☐ ACAT (HCP) ☐ RAS (CHSP)		
Discuss Service Prices with Clients: ☐ Completed		Name of Intake Staff Member:		

*External referrers: please email form to **referrals@hospitalresearch.org.au***
Office Use only

- *Once completed, please save in the client SharePoint folder and update CRM details.*

Client Details Reviewed and updated:		Reason for Update	
Name:	Date:	☐ Annual Update	☐ Update of info
Name:	Date:	☐ Annual Update	☐ Update of info
Name:	Date:	☐ Annual Update	☐ Update of info
Name:	Date:	☐ Annual Update	☐ Update of info
Name:	Date:	☐ Annual Update	☐ Update of info