The Hospital Research Foundation Group
Parkinson's

The Hospital Research Foundation Group
Stroke

CLIENT DETAIL/REFERRAL FORM

As we are partially funded by the Commonwealth Home Support Programme, and to ensure we are able to provide the most appropriate support for you, we are required to gather personal, medical and statistical data to report back as de-identified information to the Australian Government. Please complete the information below in as complete detail as possible and return this form in person to 25 King William Rd UNLEY, post to Locked Bag 1 REGENCY PARK SA 5010 or email to info@parkinsonssa.org.au.

PERSONAL DETAILS

First Name:		Preferred Name:		Last Name:	
Gender Identity:	☐ Male ☐ Female ☐ Non-Binary ☐ Other.....			Date of Birth:	
Address:					
Mobile/Phone Number:		Email:			
Medicare Card No:		Individual Reference No:			
Country of Birth:		Cultural Identity/ Ancestry:		Language Spoken:	
Interpreter Required?	☐ Yes ☐ No	I identify as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Prefer not to say		

I am a person with/who has had a: (please tick relevant box)

☐ Parkinson's disease
☐ Stroke
☐ Progressive Supranuclear Palsy (PSP)
☐ Essential Tremor
☐ Dystonia
☐ Multiple System Atrophy (MSA)
☐ Corticobasal Degeneration(CBD)
☐ Lewy Body Dementia (LBD)
☐ Other Neurological/Movement Disorder
please specify .....

Year of diagnosis:

Do you have someone who supports you and acts as a Primary Support Person? ☐ Yes ☐ No → This person is my: ☐ Spouse/Partner ☐ Child ☐ Other family member ☐ Paid Carer

Living Arrangements: ☐ I live alone ☐ I live with family member(s) ☐ I live with others

Accommodation Setting: ☐ Private residence (owned) ☐ Private rental ☐ Public rental ☐ Boarding house/SRF ☐ Independent living/Retirement Village ☐ Other .....

Source of Income: ☐ Pension - Aged ☐ Disability ☐ Carer Payment ☐ Unemployment ☐ DVA Gold ☐ DVA White ☐ DVA Other ☐ Self funded retiree

PRIVACY CONSENT

I have been provided with THRFG - Parkinson's Privacy Information. I understand that the information that I give on this form will be retained and used by THRFG - Parkinson's to provide services and support to me. I also understand that some of the information on this form will be used for statistical purposes by the appropriate government funding body without identifying me.

Signature: ..... ☐ Verbal consent obtained during phone call Date: ..... / ..... / .....

Please complete reverse of this form.

FUNDING / YOUR CARE TEAM DETAILS

Are you funded through:

☐ no funding

☐ National Disability Insurance Scheme (NDIS) → NDIS Number: .....

☐ Self Managed

☐ Plan Managed → Provider Contact Details: .....

☐ My Aged Care (MAC) → Referral Code: .....

☐ Chronic Disease Management Program (CDMP) ☐ Mental Health Care Package (MHCP)

GP Details:

Regular Doctor Name: | Provider Number:

Surgery Name and address:

Phone Number: | Fax Number:

Specialist Details:

Name: | Specialty: ☐ Neurologist ☐ Geriatrician

Surgery Address: | Phone Number:

PRIMARY SUPPORT / CARER DETAILS

First Name: | Preferred Name: | Last Name:

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Other..... | Date of Birth:

Address:

Mobile/Phone Number: | Email:

Country of Birth: | Cultural Identity/ Ancestry: | Language Spoken:

Interpreter Required? ☐ Yes ☐ No | I identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Prefer not to say

My relationship to the person for whom I care is (please tick relevant box)

☐ Spouse/Partner
☐ Son/Daughter
☐ Other relative
☐ Parent
☐ Son-in-law/Daughter-in-law
☐ Friend/Neighbour

Do you live with the person for whom you provide care? ☐ Yes ☐ No

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Signature: ..... ☐ Verbal consent obtained during phone call Date: ..... / ..... / .....

REFERRAL REQUEST

Referral from

☐ GP ☐ Specialist ☐ Self ☐ Other .....

Service requested

☐ Occupational Therapy ☐ Nursing ☐ Counselling/Coaching/Wellbeing
☐ Support Group/ Peer Support ☐ Recreational Support ☐ Dietician ☐ Speech Pathology

Purpose of Referral/Background (please detail as appropriate):

Any other relevant medical history?

Name: _____ Signed: _____ Date: _____

OFFICE USE ONLY *Date Received __/__/__* ☐ *Details entered into database* ☐ *Client contacted* ☐ *Waitlisted (if required)*
once completed form to be placed in confidential tray in DEX cupboard for PDFing into file and confidentially destroyed