Frankston City Council
Family Health Support Services

HOME AND COMMUNITY CARE REFERRAL FORM (for Clients Under 65 years of age)

Civic Centre, Corner Young & Davey Streets, Frankston, Vic, 3199
Phone: 9784 1933 Fax: 9784 1770
Email: intake@frankston.vic.gov.au Web: www.frankston.vic.gov.au
Please fax or email the completed referral form

CLIENT	
Last / Family Name:	**First Name:**
Title: **Mrs ☐ Ms ☐ Miss ☐ Mr ☐**	**Gender:** **Female ☐ or Male ☐**
Address:	
	P/Code:
Phone:	**Mobile:**
Date of Birth: _____ / _____ / _____	**Does Client Identify as:** **Aboriginal ☐ or Torres Strait Islander ☐**
Please state payment type: **Disability Support Pension ☐ Carer Allowance ☐ Carer Payment ☐** **Other ☐ If Other, what type of payment? _____** **Department of Veterans Affairs (DVA) Gold ☐ Blue ☐ White ☐ Orange ☐ Other ☐**	
Has the Client registered for NDIS (National Disability Insurance Scheme)? **Yes ☐ No ☐ Unknown ☐** **If YES, what is the status** **Access met ☐ Plan approved ☐ Did not meet access ☐**	
CARER	
Does client have a Carer? Yes ☐ No ☐	
If yes, Carer Last / Family Name:	**Carer First Name:**
Carer Address:	
	P/Code:
Carer Date of Birth: _____ / _____ / _____	**Client relationship to carer:**
Carer Phone:	**Carer Mobile:**
Is Carer in receipt of Carer Payment or Allowance? Yes ☐ No ☐ **Is Carer in receipt of another Centrelink Payment? Yes ☐ No ☐ If yes, type:_____**	

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ALTERNATIVE / EMERGENCY CONTACT	
Last / Family Name:	**First Name:**
Address:	
	P/Code:
Phone:	**Mobile:**
Relationship to client:	

REFERRER	
Organisation:	
Last / Family Name:	**First Name:**
Address of organisation:	
	P/Code:
Phone:	**Mobile:**
Fax:	**Email:**

SERVICE TYPE REQUESTED

Meals on Wheels	☐	**Personal Care**	☐
Shopping (escorted)	☐	**Respite Care**	☐
Shopping (unescorted)	☐	**Home Maintenance**	☐
Home Care	☐	**MEPACS (Personal alarm)**	☐
Community Transport (Shopping/Library bus)	☐	**Planned Activity Groups (PAG)**	☐

REASON FOR REFERRAL

PRIORITY

Low ☐ **Medium** ☐ **High** ☐ **Urgent** ☐

Priority Comment:

RISK

Client Risk (if any):

Worker Risk (if any):

Frankston City Council OH&S Risk (if any):

SIGNIFICANT CLIENT HISTORY

OTHER RELEVANT INFORMATION

CONSENT
Does client consent to referral? **Yes** ☐ **No** ☐
Signature of Referrer: _____
Date of Referral: _____ **/** _____ **/ 20** _____

FURTHER COMMENTS