QUALITY HEALTHCARE SOLUTIONS

REFERRAL FORM

Applicant Name *

Postal Address

Postcode

Phone *

Email Address *

How did you hear about us? *

APPLICANT TO COMPLETE

First Name *

Surname *

Preferred Name

Date of Birth *

Home Address *

Postcode *

Home Phone

Mobile *

Email Address *

Gender

Relationship Status

QUALITY HEALTHCARE SOLUTIONS

REFERRAL FORM

Aboriginal/ Torres Straight Islander

☐ YES ☐ NO

Ethnicity

Country of Birth

Culturally and Linguistically Diverse (CALD)

☐ YES ☐ NO

Primary Spoken Language

Do you require an interpreter?

☐ YES ☐ NO

Do you have any dependants?

☐ YES ☐ NO

What is your Australian residency status?

Do you have an Occupation?

Source of income

☐ Age Pension ☐ Carer Allowance ☐ Disability Pension ☐ Department of Veteran's Affairs

☐ Family Assistance ☐ Unemployment (Newstart) ☐ Youth Allowance ☐ Paid Work

☐ Other

Living Situation

☐ Living Independently ☐ Living with family member/ carer ☐ Other

Hold a DVA Card?

☐ YES ☐ NO ☐ Gold ☐ White ☐ Other

CONTACTS

Nominated support person (Next of kin / Alternative contact)

Name

Phone

Mobile

Email

Relationship

QUALITY HEALTHCARE SOLUTIONS

REFERRAL FORM

Do you have a Case Manager?

☐ YES ☐ NO

Do you have a Guardian Appointed?

☐ YES ☐ NO

Do you have a Public Trustee?

☐ YES ☐ NO

Do you have a GP?

☐ YES ☐ NO

Name

Phone

Mobile

Email Address

Which of the below is your preferred contact?

☐ Support Person ☐ Case Manager ☐ Guardian Appointed ☐ Public Trustee ☐ GP

Preferred method of contact?

☐ Text ☐ Phone Call ☐ Email ☐ Mail ☐ GP

AREAS OF REQUIRED SUPPORT

Existing NDIS Plan (please attach)

☐ YES ☐ NO

NDIS Plan Number

Current Disability *

☐ YES ☐ NO

If yes, please provide details:

QUALITY HEALTHCARE SOLUTIONS

REFERRAL FORM

What areas of support would you like assistance with?

What supports (if any) have you found helpful for living with your disability?

What are your interests?

What are your dreams and aspirations?

HEALTH AND WELLBEING

Any mental health issues you currently receive treatment or support for?

☐ YES ☐ NO

If yes, please briefly describe any past and current treatment/support?

QUALITY HEALTHCARE SOLUTIONS

REFERRAL FORM

Any physical health concerns you currently receive treatment or support for?

☐ YES ☐ NO

If yes, please briefly describe any past and current treatment/ support??

Please describe how living with disability impacts your life.

Do you have any legal issues, such as :- outstanding charges, convictions, or a community treatment order?

☐ YES ☐ NO

If yes, please provide details:

Do you have any Alcohol or Drug issues?

☐ YES ☐ NO

If yes, please provide details:

REFERRAL FORM

Are you linked in with any Alcohol or Drug services?

☐ YES ☐ NO

If yes, please provide details:

CONSENT

I acknowledge the information provided is true and correct. I consent to Quality Healthcare Solutions contacting my community service and healthcare providers to gather additional information to support this referral if necessary.

Name of consenting applicant *

Signature of consenting applicant *