REFERRAL FORM
Respite Service Coordination

All referrals must meet the program eligibility criteria as follows:

- Must have a diagnosed disability as per the Disability Act 2006
- Must be aged between 6 & 64 years
- Must live with a primary carer
- Must live within the Eastern Metropolitan Region
- Does NOT have an allocated Case Manager

All personal and health information collected will be treated confidentially and will only be used for the purposes of assessing your eligibility for this service.

We are also required to release certain statistical information about our service users to the Department of Human Services (DHS) in order to monitor existing services, plan for future services and for statistical purposes. It is important to note that no directly identifying information such as your name or contact details will be provided to external agencies. There will be no direct consequences in terms of you receiving services should you choose not to consent to de-identified information being released. However, your information would be very useful in assisting to plan better services for you and other people with a disability.

- Please indicate if you consent to non-identifying information being provided to the Department of Human Services (DHS) for the purposes detailed above:

(please tick) ☐ Yes ☐ No Signed: _____

This application is being completed by:

Name: _____ **Relationship/Role:** _____

Contact Details: _____ **Signed:** _____

Individual's Details

Name of person/s you are referring: _____

Gender: ☐ Male ☐ Female

Date of birth: ...../...../..... Is this date of birth an estimate? ☐ (If yes, please tick)

Address: _____

Suburb _____ Post code _____

Home Tel: _____ Work Tel: _____

Mobile Tel: _____ Local Govt Area: _____

E-Mail: _____

Does this individual have a Case Manager?* ☐ Yes ☐ No

Name: _____ **Organisation:** _____

Contact Details: _____

*** Please note that if the individual has a Case Manager, they are not eligible for this program**

Key contact person regarding this referral:

Name: _____

Agency (if applicable): _____

Phone Number: _____

Relationship to person being referred: _____

Is the individual of Aboriginal or Torres Strait Islander (TSI) origin?

☐ Aboriginal but not TSI origin ☐ TSI but not Aboriginal origin

☐ Both Aboriginal and TSI origin ☐ Neither Aboriginal nor TSI origin

In which country was the individual born?

☐ Australia ☐ Other Country, please specify…… ……..

What is the main language spoken in the individual's home?

☐ English ☐ Other language, please specify……..……

Does the individual or individual's carer require interpreter services?

☐ Yes – for spoken language other than English ☐ Yes – for non –spoken communication ☐ No

What is the individual's most effective form of communication?

☐ Spoken language ☐ Sign language

☐ Other effective non-spoken communication ☐ Little or no effective communication

Does the individual usually live alone or with others?

☐ Lives alone ☐ Lives with family ☐ Lives with others

What is the individual's usual residential setting?

☐ Private residence – owned or purchased ☐ Supported accommodation facility

☐ Private residence – private rental ☐ Residential aged-care facility

☐ Private residence – public rental ☐ Independent living unit within a retirement village

☐ Private residence –mobile home/caravan ☐ Boarding house/Private hotel

☐ Other – please specify: _____

Does the individual have a non-paid primary carer who provides regular support?

☐ Yes ☐ No

Does the primary carer live in the same household as the individual?

☐ Yes ☐ No

Does the primary carer assist in the areas of Self Care, Mobility or Communication?

☐ Yes ☐ No

Is the primary carer a sole carer?

☐ Yes ☐ No

What relationship is the primary carer to the individual?

☐ Parent ☐ Wife/Husband/Partner ☐ Daughter/Son

☐ Sibling ☐ Other – please specify: _____

How old is the primary carer?

☐ Under 15 yrs ☐ 15-24 yrs ☐ 25-44 yrs ☐ 45-64 yrs ☐ 65-79 yrs ☐ 80 yrs+

How would you describe the general health of the primary carer?

☐ Good ☐ Average ☐ Poor

Is there more than one person with a disability in the carer household?

☐ No ☐ Yes, please provide details:……..

Does the carer have caring responsibilities for other family members (eg: aged relatives/ other children)?

☐ No ☐ Yes, please provide details:……..

Does the carer household rely on the pension as its sole income?

☐ Yes ☐ No, but low income ☐ No

Does the individual's primary carer receive the Carer Allowance?

☐ Yes ☐ No ☐ Not known

Does the individual attend school, day placement , supported employment or other?

☐ Full Time ☐ Part time ☐ Not at all

Name of school/day placement/employment: _____

Contact Person: _____ **Contact Number:** _____

Address: _____

What is the individual's diagnosed disability?

Specific Diagnosis (eg Down Syndrome, Cerebral Palsy, Muscular Dystrophy): _____

(Please attach any relevant medical or psychological reports)

Primary Disability *(please tick one box)*		Secondary Disability *(please tick as many boxes as required)*
☐	Intellectual	☐
☐	Specific learning/ADD	☐
☐	Autism	☐
☐	Physical	☐
☐	Acquired Brain Injury	☐
☐	Neurological (including epilepsy and Alzheimer's Disease)	☐
☐	Deafblind – dual disability	☐
☐	Vision	☐
☐	Hearing	☐
☐	Speech	☐
☐	Psychiatric	☐
☐	Development Delay (Only valid for a child aged 0-5 years)	☐

Does the individual have any complex medical needs that would require specific training?
e.g.Gastrostomy, seizure management, catheterisation etc

☐ No ☐ Yes please specify ……..

Does this limit the individual's access to respite?

☐ No ☐ Yes please specify:

_____

Does the individual display challenging behaviour?

☐ No ☐ Yes please specify:

_____

Is the individual employed? Only answer if individual is <u>15 years or over</u>.

☐ Employed ☐ Unemployed ☐ Not in the labour force ☐ Not applicable

What is the individual's main source of income? Only answer if individual is <u>16 years or over</u>.

☐ Disability Support Pension ☐ Other pension or benefit ☐ Paid employment
☐ Compensation payments ☐ Other income ☐ No income ☐ Not known

PARTICIPATION (Please tick the box that best describes the applicants participation)

To what extent does the individual participate in the following:

	Fully	Partially	Not at all	Not known

GETTING AROUND OUTSIDE (mobility)?	☐	☐	☐	☐
USING TRANSPORT?	☐	☐	☐	☐
MAINTAINING RELATIONSHIPS WITH FAMILY?	☐	☐	☐	☐
MAINTAINING SOCIAL RELATIONSHIPS (friendships)?	☐	☐	☐	☐
RECREATION OR LEISURE ACTIVITIES?	☐	☐	☐	☐
WORKING?	☐	☐	☐	☐
HANDLING MONEY?	☐	☐	☐	☐

Please indicate the support required by the individual in the following areas:
(Please tick appropriate box)

	Dependent	Needs some assistance	Independent with use of aids/equipment	Independent	Not applicable
Mobility					
Employment/working					
Self Care					
Meal time assistance					
Domestic Tasks					
Interpersonal Interactions/relationships					
Learning, applying knowledge/general tasks and demands					
Community Access/Economic Life					
Education					
Communication					

Is the individual currently receiving individualised funding? (*ISP*)

☐ Yes ☐ No ☐ Not known

Is the individual registered with the Department of Human Services?

☐ Yes ☐ No ☐ Not known

Is the individual currently on the Disability Support Register? (*DSR)*

☐ Yes ☐ No ☐ Not known

Does the individual have a CRISS number?

☐ Yes ☐ No ☐ Not known

Please Provide……

How did you find out about Yooralla's Respite Service Coordination Program?

What services does the individual currently access?

In Home Support ☐ Yes ☐ No
Service Provider Name: _____

HACC (Council Support) ☐ Yes ☐ No
Service Provider Name: _____

Facility Based Respite ☐ Yes ☐ No
Service Provider Name: _____

Recreation/Youth Group/Social Group ☐ Yes ☐ No
Service Provider Name: _____

School Holiday Programs ☐ Yes ☐ No
Service Provider Name: _____

Case Management ☐ Yes ☐ No
Service Provider Name: _____

Was the referral form easy to understand and complete? ☐ Yes ☐ No

Eligibility for services under the Disability Act 2006:

Please Note:
Prior to registration with this program you may be required to undertake a target group assessment to determine eligibility under the Disability Act 2006. This means that you may be contacted to provide additional information about the individual's diagnosis of disability (including medical and/or psychological reports). If you have these available, please attach these to the referral to assist with this process. All information will be treated confidentially.

On completion please return this form to:

Eastern Metropolitan Region:
Yooralla
Respite Service Coordination
Suite 2/587 Canterbury Road, Surrey Hills VIC 3127
Telephone: (03) 9831 5600 Fax: (03) 9830 0003