

Cara Referral Form - Number AO-14 (1)

To: **Referral Review Committee** Date: _____

Name: (of potential consumer) _____

Sex: M/F _____ Date of Birth: _____

Address: _____

Post Code: _____

Telephone No.: _____ Work: _____

Mobile: _____ Email: _____

Fax: _____

Country of Birth: _____

Is the potential service user of **Aboriginal** or *Torres Strait Islander*

origin? Aboriginal but not Torres Strait Islander origin 1

Torres Strait Islander but not Aboriginal origin 2

Both Aboriginal and Torres Strait Islander Origin 3

Neither Aboriginal nor Torres Strait Islander origin 4

Responses must not be based on the perceptions of anyone other than the person, or their advocate. The 'look' of a person has proven to be an unreliable way for another person to assess someone's Indigenous origin

Service Coordinator's Name / Agency / Region:

Name of Referee and Contact Details:

Name of Parent / Legal Guardian / Caregiver (if appropriate):

Relationship to Consumer: _____

Address (if same as potential consumer, write AS ABOVE):

Post Code: _____

Telephone No.: _____ Work: _____

Mobile: _____ Email: _____

Fax: _____

How do you prefer to be communicated with?

Letter

Phone

Email

Does the potential service user usually **live alone** or **with others**?

Lives alone 1

Lives with family 2

Lives with others 3

Usually' means 4 or more days per week on average. The service user's living arrangements must relate to the same place described in residential settings (see question 9)

Interpreter Required:

Yes

No

Main language spoken at home? _____

Comment: _____

Are there any safety issues that Cara staff need to be aware of when visiting the potential consumer's home? Yes No

If yes, please provide Risk Analysis, comments:

.....

What are the potential consumer's **primary** and **other significant disability group(s)**

a. Primary disability group

b. Other significant disability group(s)?

Tick 1 box only	<input type="checkbox"/> 1	Intellectual	<input type="checkbox"/>	Tick all other significant disabilities.
	<input type="checkbox"/> 2	Specific learning / ADD - other than Intellectual	<input type="checkbox"/>	
	<input type="checkbox"/> 3	Autism - including Asperser's syndrome	<input type="checkbox"/>	
	<input type="checkbox"/> 4	Physical	<input type="checkbox"/>	
	<input type="checkbox"/> 5	Acquired brain injury	<input type="checkbox"/>	
	<input type="checkbox"/> 6	Neurological - including epilepsy & Alzheimer's Disease	<input type="checkbox"/>	
	<input type="checkbox"/> 7	Deaf blind - dual sensory	<input type="checkbox"/>	
	<input type="checkbox"/> 8	Vision	<input type="checkbox"/>	
	<input type="checkbox"/> 9	Hearing	<input type="checkbox"/>	
	<input type="checkbox"/> 10	Speech	<input type="checkbox"/>	
	<input type="checkbox"/> 11	Psychiatric	<input type="checkbox"/>	
	<input type="checkbox"/> 12	Developmental Delay - only valid for a child aged 0 - 5 years	<input type="checkbox"/>	

Disability group (s) (other than indicated as being 'primary') that also causes difficulty for the person.

N.B. This referral will not be processed unless all details are completed.

1. Health Support Information

Health Support Level: Refer to Guidelines for Provider Agency Mangers and Case Managers (Brokers) in the Provision of Health Support to People with Disabilities (DSP-15A) for definitions (complete Attachment 1 to assist your decision, marking and tick appropriate box)

1 2 3 Unsure

Does the person have any health support requirements? Yes No

If yes provide details: ie: gastrostomy nutrition, asthma / seizure management etc.

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2. Identify Current Health / Support Plans:

Has a health assessment been undertaken by a registered nurse / medical practitioner for the purpose of determining the need for a Health Plan? Yes No

If yes what was the outcome of the health assessment? (tick appropriate box)

- Health Plan not required
- Health Plan (for level 3 health support developed by a registered nurse)
- Health Care Plan (for level 2 health support developed by a medical practitioner)

Where are the Health / Support Plan currently used?

- Community Child Care setting
- School setting (DECS)
- Accommodation
- Respite
- Day Options Program
- Other

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3. Identify other Support Plans

Does the person have other support requirements? Yes No

Please provide any other information necessary for Cara to provide safe support

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Does the person have specific requirements at mealtimes? Yes No

Is there an Oral Eating & Drinking Plan in place? Yes No

Please provide any other information necessary for Cara to provide safe support:

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Does the person have specific behaviour management requirements?

Yes No

Is there a Behaviour Management Plan in place?

Yes No

Please provide any other information necessary for Cara to provide safe support:

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Does the person require specific Manual handling requirements? Yes No

Is there a Manual Handling Plan in place? Yes No

Please provide any other information necessary for Cara to provide safe support:

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Equipment required by consumer:

- | | |
|--|---|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Electric wheelchair |
| <input type="checkbox"/> Pusher | <input type="checkbox"/> Walker |
| <input type="checkbox"/> AFO's | <input type="checkbox"/> Lifter, if yes, do they have their own sling? Y / N |

- Slide board
- Toilet chair
- Bath chair
- Other – please specify:
- Standing frame
- Shower chair
- Spinner seat

4. What Agencies, Services, Venues currently accessed: (provided service location details)

- Community Child Care.....
- School settings
- Accommodation.....
- Respite
- Day Options Program.....
- Other

To accept this referral Cara requires:

- All fields of this form completed
- A completed Options Coordination Agency Risk Analysis must be attached
- Attachment 1

Consumer:

What other services is the Consumer / Family receiving? (e.g. IDSC, APN, BIOC, FAYS, Schools)

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Reason for Referral:

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<i>To be completed by designated officer after Referral Review Committee</i>	
Referral Received	Date:
<input type="checkbox"/> Referral Accepted	Date:
<input type="checkbox"/> Referred back to Referral Source	Date:
Reason for Referral back to Source:	
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.....	
Other Comments:	
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Attachment 1 (DSP 15A)

The chart below will assist in determining if client's health support needs are Level 3 or the advice of a registered nurse is needed to assist in determining the level.

All the ticks need to be in the "Yes" box to proceed without Registered Nurse advice. Any "No" or "Unsure" ticks indicate that the support needs are Level 2 or 3 and will need Registered Nurse referral.

Indicators	Yes	No (<i>Refer to Registered Nurse</i>)	Unsure (<i>Note why and seek clarification</i>)
Support needs are clear			
Medical condition is stable and predictable			
Support required can be undertaken by a care worker with basic training			
When undertaking the procedure, care worker is required to exercise judgement only within their competency and responsibility			
The supervisor confirms the care worker is competent and able to undertake the task			
The task is straightforward and non-invasive			
Medical documentation enables the support needs to be clearly understood			
Documentation to support decision making is relevant / current			
There is adequate time available to plan the level of support required			