



Gateway Social Support Options Inc. 43 Paxton Street, Spotswood 3015
Phone 9399 3511 Fax 9399 5081

Client Referral Form

Confidential Cover Sheet

Gateway Social Support Options (GSSO) provides Home and Community Care (HACC) funded social support to frail older people, people with disabilities and their carers. Referrals will be evaluated according to client's level of disability, risk or need and then prioritised.

Please contact Intake Officer at Gateway to discuss Program vacancies and suitability prior to making a referral for social support.

Date sent: _____

Number of pages: _____

Referral from: _____

Name: _____

Position: _____

Organisation: _____

Phone: _____

Fax: _____

Email address: _____

Address: _____

Does the referring agency wish to be advised of the estimated date of assessment?

Yes No

Does the referral person wish to be present at the assessment?

Yes No

Who is the recommended contact person for initiating an assessment?

Client directly Referring person Carer

10-Jul-09

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Client Details

Family name: _____ Given name: _____

Date of birth: _____ Sex: _____

Address: _____

Suburb: _____ Post Code: _____

Phone: _____ (home) _____ (mobile)

Country of Birth: _____ Languages: _____

Do you recommend an advocate or interpreter for this referral: Yes No

Has the client been informed about this referral? Yes No

Type of consent: Verbal Written

Emergency Contact Person

Name: _____ Relationship: _____

Address: _____

Suburb: _____ Post Code: _____

Phone: _____ (home) _____ (mobile)

Is this person the primary carer? Yes No

Reason for referral

Program preferences >>>> Fishing Woodwork Flexi Respite
 Hydro Movies Markets Golden Gals and Pals Friendly Visiting

Eligibility for Home & Community Care Social Support

1. How does the client meet the HACC criteria?

- Frail older person Person with a disability
 Has a carer Does the client: live with their carer or live independently?
Level of dependency on the carer: High Med Low
 Culturally & Linguistically Diverse (C.A.L.D.) Financially disadvantaged
 Aboriginal / Torres Strait Islander

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2. Does the client receive a Funded Care Package? Yes No

If Yes, Type of package _____

3. Is the client being case managed? Yes No

Case Manager Name and Agency: (if different from referring person) _____

Type of case management service: _____

4. Does the client have the ability to be socially independent? Yes No Limited

5. Does the client attend other social group activities? Yes No Limited

6. Does the client drive a car? Yes No Limited

7. Can the client manage public transport? Yes No Limited

8. Can the client manage activities/tasks of daily living? Yes No Limited

9. Do you consider this client to be at risk of isolation and pre-admission to long term institutionalised care? Yes No

If yes please rate from 1 to 3, with 1 being the greatest risk. 1. 2. 3.

Current Health Profile & Support Needs

1. Please list health conditions for the client and functional limitations, eg. mobility, cognitive

2. Please describe all relevant support needs? E.g. Supervision, mobility _____

3. Significant past histories: _____

4. Medical Practitioner _____ Phone _____

5. Medication _____

6. Any allergies ? Yes No If yes, give details _____

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7. List any known OH&S hazards at client's residence? _____

End of referral form. Please fax to 9399 5081

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