CLIENTS DETAILS FORM

East Coast Accessibility Experts

Staff Member conducting the Client assessment:

P: 02 6651 2143

E: admin@accessibilityexperts.org.au

CLIENT DETAILS:

Surname: ..... **Given Names:** .....

Address: .....

Suburb: .... **Phone:** .....

Gender: Male.....☐ .....Female ☐ **Place of Birth:** .....

Date of Birth: ..... **Main Language:** .....

Interpreter Required | Yes ☐ No ☐ **Religion:** .....

Aboriginal or Torres Strait Islander | **Yes ☐ No ☐**

Has a My Aged Care Referral been made | ..... **Yes ☐ No ☐**

My Aged Care Referral Code No. .....

Pension: Aged ☐**.....**Disability ☐**.....**DVA ☐ **OR: .....**Self-funded ☐ **.....**Other ☐

EMERGENCY CONTACT DETAILS

Surname:..... **Given Names:** .....

Relationship to Client: ....

Address: .....

Suburb: ..... **Postcode:**.....

Phone:..... **Mobile:** .....

CARER DETAILS

Surname:..... **Given Names:** .....

Phone:..... **Mobile:** .....

Relationship to Client: ..... **Male/Female**

Date of Birth: ..... **Place of Birth:** .....

Residential Status: ..... Co-resident ☐ **.....**Non-resident ☐

Main Language ..... **Interpreter Required ...Yes ☐ ....No ☐**

Aboriginal or Torres Strait Islander .....Yes ☐ .....No ☐

Does the carer, care for more than one? .....Yes ☐ .....No ☐

GP DETAILS	REFERRAL DETAILS
Name:	**Date:** .....
Address:	**Name:** .....
.....	**Agency:** .....
Suburb:	.....
Postcode:	**Days of work** .....
Phone:	**Phone:** .....
Fax:	**Mobile:** .....
	Phone: .....
	Fax: .....
	Email: .....

CLIENTS LIVING ARRANGEMENTS

Alone ☐ Spouse/partner only ☐ With Relatives ☐ Other ☐

Name and Contact Details: .....

TENURE

Own Home ☐ .....With Family ☐ **.....**Rents Private ☐ **.....**Community/Public Housing ☐

Case Manager Contact Details: .....

.....

(Landlord/Body Corporate/Housing permission must be given in writing for private/public rental situations. Please attach a ECAE Authority to Install sheet with the referral) and/or Strata permission to install documentation.

IS THE CLIENT IN RECEIPT OF HOME CARE PACKAGE or NDIS?

☐ **YES** ☐ **NO** Level ☐ 1, ☐ 2, ☐ 3 or ☐ 4

If yes, Package Provider Name and Contact Details |.....

.....

.....

.....

FUNCTION DISABILITY

Disability:	☐ Yes	☐ No	**Frail Aged:**	☐ Yes	☐ No
Dementia:	☐ Yes	☐ No	**Hearing Aides:**	☐ Yes	☐ No
Frame:	☐ Yes	☐ No	**Wheeled Walker:**	☐ Yes	☐ No
Wheelchair:	☐ Yes	☐ No	**Walking Stick:**	☐ Yes	☐ No
Palliative:	☐ Yes	☐ No			

Other: .....

WHAT ARE THE IMPLICATIONS FOR THE CLIENT IF WORK IS NOT COMPLETED?

Reduced Independence ☐ Risk of injury to self or others ☐

Details: .....

ESSENTIAL QUESTION AND DOCUMENTATION

Do you have an Advocate/POA/Guardianship|..... ☐Yes..... ☐No .....

Contact Details | .....

Attach Documents.....

CONFIDENTIALITY STATEMENT

This is to inform you that information collected by Commonwealth Home Support programs, ie Home Modification service, is required by the Funding Body, Commonwealth Department of Health. This information is used for research and planning purposes and will not affect supports you are entitled to receive. Identifying information such as name and address will NOT be forwarded to any department.

CLIENT/CARER CONSENT

I, ... client ☐ carer ☐ advocate ☐

Address: .....

consent to this Referral being lodged with East Coast Accessibility Experts and any relevant information in this referral being made available to mutually agreed supports, including other CHSP support provided by East Coast Accessibility Experts other CHSP or Home Care Package related partnership programs provided through East Coast Accessibility entities contract by East Coast Accessibility Experts to provide supports to clients.

Signature ..... Date___/___/20___

Verbal Agreement if client is unable to sign ☐ Yes ☐ No

I agree to photos and/or footage taken of me by East Coast Accessibility Experts to be printed and published in any manner anywhere and at any time without limit.

YES ☐ NO ☐ Signature:……..