Country Therapy

REFERRAL FORM FOR MEDICARE PARTICIPANTS

1. PARTICIPANT DETAILS

First Name:	Last Name:
Date of Birth:	Phone:
Gender: Male Female Prefer not to say	Email:
Address: Suburb: State: Postcode:	
Alternative Contact: (*in case the participant or Support coordinator is unreachable*) Name: Phone: Relationship: Email:	
MEDICARE NO:_____	

2. REFERRER DETAILS

Check this box if you are referring yourself and move to **section 3**

Name of Organisation: (if applicable)	
First Name	Last Name:
Phone:	Postcode:
Email:	
Job Title / Role: Support Coordinator Case Manager Local Area Coordinator Family member Other:	

3. Diagnosis:

4. Security

*(In order to proceed with your referral ALL questions **MUST** be ticked.)*

Is anyone at your / the client's property, known to be aggressive, violent or a criminal history ? If Y – please advise:	Y N
Does anyone at your/the clients property smoke? If Y – please advise:	Y N
Does the client have a positive behavioural support plan in place? If Y – please attach a copy of PBS	Y N

Is there a history of drugs or alcohol misuse at the property? If Y – please advise:	Y N
Are you aware of any firearms being stored at the property? If Y – please advise:	Y N
Are you aware of any occupant having an infectious disease? (i.e. chicken pox / shingles / gastro, etc.) If Y – please advise:	Y N
Do you have any pets at your premises?	Y N
Are there any other factors we should be aware of? If YES, please describe:	Y N

5. Accounts Information :

Who is responsible for paying the account / invoice? (please select one)
Plan Managed - Organisation Name:
Self-Managed

For Plan Manager or Self Managed, please complete the following details:
Name of person responsible for the account:
Phone:
Email:

6. Reason for Referral/Concerns: (Please describe support required)