

## 4.2.1A REFERRAL TO CBS



**Community  
Based  
Support**

Maximising client independence

24 Sunderland St or PO Box 823  
Moonah Tas 7009  
Phn: (03) 6208 6600 Fax: (03) 6208 6699  
E-mail: admin@cbsaust.org.au  
Amended 30/08/2017

### Client personal details

<b>Title/First Name</b>	<input type="text"/>	<b>Home Phone</b>	<input type="text"/>
<b>Surname</b>	<input type="text"/>	<b>Mobile Phone</b>	<input type="text"/>
<b>Date of birth</b>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Doctor</b>	<input type="text"/>
<input type="checkbox"/> Tick if date of birth is estimated		<b>Doctor Phone</b>	<input type="text"/>
<b>Sex</b> <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female		<b>Emergency Contact</b>	<input type="text"/>
<b>Street Address</b>	<input type="text"/>	<b>Phone</b>	<input type="text"/>
<b>Suburb/Town</b>	<input type="text"/>	<b>Country of birth</b>	<input type="text"/>
<b>Postcode</b>	<input type="text"/>	<b>Main language</b>	<input type="text"/>

<input type="checkbox"/> Personal Care <input type="checkbox"/> Respite Care <input type="checkbox"/> Social Support <input type="checkbox"/> Home/Garden Maintenance <input type="checkbox"/> Spring Cleaning <input type="checkbox"/> Home Modification <input type="checkbox"/> Emergency <input type="checkbox"/> Dom Assist <input type="checkbox"/> Other <input type="checkbox"/> Technical Services	<b>Level of support required</b>	<b>Are other ongoing services received?</b> <input type="checkbox"/> Home & Community Care (HACC Under 65) <input type="checkbox"/> Commonwealth Home Support Programme (CHSP Over 65) <input type="checkbox"/> Home Care Package (HCP) <input type="checkbox"/> Veterans Home Care <input type="checkbox"/> Disability Services - ISP <input type="checkbox"/> NDIS								
	<b>Reason for support</b>									
	<b>Specific tasks required/work description</b>									
	<i>Technical Services Only</i> <input type="checkbox"/> Rail <input type="checkbox"/> Ramp <input type="checkbox"/> Bath-board <input type="checkbox"/> Wheelchair maintenance <b>Materials</b>									
		<table border="1"> <thead> <tr> <th>Hours</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>	Hours	Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### HOME AND COMMUNITY CARE (HACC) MINIMUM DATA SET CONFIDENTIALITY STATEMENT

Please note that **Community Based Support Inc** may release information about HACC clients (without identifying you by full name, or address) to the Department of Health and Human Services and to the National or State Data Repository.

The HACC funded organisation from which you are receiving care in the community is required to collect information about all of its services and consumers, and to send this information to a central office of the Home and Community Care Program (HACC) for monitoring and planning purposes. This will enable HACC to ensure that resource levels are adequate and the right services are in place to meet demand.

This process enables the collection of information about HACC services and their consumers. The information will be kept confidential. This information is to be used for statistical purposes only and will not be used to affect your entitlements to, or your access to, services.

The information is to be added to a large collection (repository) at the State or National administering Department and used for statistical purposes only. It cannot be used to affect your entitlements to, or your access to, services.

This statement concerns only the HACC data collected and transmitted to the National or State Data Repository.

## Referral Information

### Agency Name

### Person Referring

### Telephone

### Fax

### E-mail

The person being referred is / is not HACC eligible

.....  
Signature of Referrer

### Source of Referral

- 1. Self
- 2. Family, significant other, friend
- 3. GP/medical practitioner – community based
- 4. Aged Care Assessment Team
- 5. Community nursing or health service
- 6. Hospital
- 7. Psychiatric/mental health service
- 8. Extended care/rehabilitation service
- 9. Palliative care service/hospice
- 10. Residential aged care facility
- 11. Aboriginal health service
- 12. Other medical/health service
- 13. Other community based service
- 14. Law enforcement agency
- 15. Other
- 99. Not stated/inadequately described

## Client personal circumstances

### Indigenous status

- 1. Aboriginal but not Torres Strait Islander
- 2. Torres Strait Islander but not Aboriginal
- 3. Both Aboriginal and Torres Strait Islander
- 4. Neither Aboriginal nor Torres Strait Islander
- 9. Not stated/inadequately described

### Does the client have a carer?

“Carer” here means someone who looks after this client by providing support that is **unpaid, regular and sustained**.

- 1. Has a carer
- 2. Has no carer
- 9. Not stated/inadequately described

### Living arrangements

- 1. Lives alone
- 2. Lives with family
- 3. Lives with others
- 9. Not stated/inadequately described

### DVA card status

- 1. DVA gold card
- 2. DVA white card
- 3. Other DVA card
- 4. No DVA card
- 9. Not stated/inadequately described

### Government pension/benefits

- 1. Aged pension
- 2. Department of Veterans Affairs pension
- 3. Disability support pension
- 4. Carer payment (pension)
- 5. Unemployment related benefits
- 6. Other government pension or benefit
- 7. No government pension or benefit
- 9. Not stated/inadequately described

### Accommodation setting

- 1. Private residence – owned/purchasing
- 2. Private residence – private rental
- 3. Private residence – public rental
- 4. Independent living unit within retirement village
- 5. Boarding house/private hotel
- 6. Short-term crisis, emergency or transitional accommodation
- 7. Supported accommodation or supported living facility
- 8. Institutional setting
- 9. Public place/temporary shelter
- 10. Private residence rented from an Aboriginal Community
- 11. Other
- 99. Not stated/inadequately described

## Client Functional Screening

### **Ability to do Housework**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Go to Places Farther Than Walking Distance**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Go Shopping for Groceries or Clothes**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Take Own Medication**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Handle Own Money**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Walk**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Bathe/Shower**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Ability to Engage in Leisure Activities**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Does the Client Have Memory Problems/Confusion?**

- 1. No
- 2. Yes
- 9. Not stated/inadequately described

### **Does the Client Have Behavioural Problems?**

- 1. No
- 2. Yes
- 9. Not stated/inadequately described

### **Additional Client Functional Screening**

### **Does the Client Need Help to Communicate?**

- 1. Yes, always
- 2. Yes, sometimes
- 3. No
- 9. Not stated/inadequately described

### **Does the Client Need Help to Dress Themselves?**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

### **Does the Client Need Help to Eat?**

- 1. Yes, always
- 2. Yes, sometimes
- 3. No
- 9. Not stated/inadequately described

### **Does the Client Need Help to Use the Toilet?**

- 1. Completely unable
- 2. Yes, with some help
- 3. No
- 9. Not stated/inadequately described

### **Does the Client Need Help to get Out of Bed and Move Around?**

- 1. Yes, always
- 2. Yes, sometimes
- 3. No
- 9. Not stated/inadequately described

## Carer Information

**Carer First given name**

**Carer Family name/surname**

**Date of birth**  DD  MM  YYYY

**Tick if date of birth is estimated**

**Sex**  1. Male  
 12. Female  
 19. Not stated/inadequately described

**Address**

**Suburb/town**

**Postcode**

**Home Phone**

**Mobile Phone**

**Country of birth**

**Main language**

**Carer indigenous status**

- 1. Aboriginal but not Torres Strait Islander
- 2. Torres Strait Islander but not Aboriginal
- 3. Both Aboriginal and Torres Strait Islander
- 4. Neither Aboriginal nor Torres Strait Islander
- 9. Not stated/inadequately described

**Does the carer live with the care Recipient?**

- 1. Yes, co-resident carer
- 2. No, non-resident carer
- 9. Not stated/inadequately described

**What is the relationship of the carer to care recipient?**

- 1. Spouse, partner
- 2. Parent
- 3. Son or daughter
- 4. Son-in-law or daughter-in-law
- 5. Other relative
- 6. Friend/neighbour
- 9. Not stated/inadequately described

**Partner's employment status?**

**Ability to fulfil role as carer**

- 1. Completely unable
- 2. With some help
- 3. Without help
- 9. Not stated/inadequately described

**Does the carer care for more than one person?**

- 1. Yes
- 2. No
- 9. Not stated/inadequately described

## Consent

I  (Client's or client's Power of Attorney name)

consent  to this information being made available to CBS

consent  do not consent  to this information being made available to organisations that CBS contract to provide my support

and I

consent  do not consent  to my personal information being de-identified and used for research purposes

Signature \_\_\_\_\_ Date \_\_\_\_\_

Comment if the client is unable to sign (ie. Verbal agreement):