WAMURAN PARK HOME

Client Referral Form

Client Surname:	Date of Birth:
Client Given Name:	Country of Birth:
Preferred Name:	Language:
Pension Number:	Medicare Number:
Expiry Date:	Expiry Date:
DSP or AGED:	
Private Health Fund / Number: Type of cover:	Health Directive:
Current address:	
Contact numbers:	

NEXT OF KIN DETAILS IF MORE THAN ONE PLEASE ATTACH SEPARATE PAGE

Name & Relationship:		Is the NOK aware of the referral?
Email:		
Home:		
Mobile:	Work:	
Address:		
Who has Power of Attorney:		
Referred by:		
Case Worker's phone and email details:		
Reason For Referral:		
Has this person had an ACAT? If yes please attach		

IS THE CLIENT WITH ADULT GUARDIAN? IF YES PLEASE INCLUDE GUARDIANS CONTACT DETAILS

Name:	
Email:	
Work:	Mobile:
Fax:	
Address:	

IS THE CLIENT WITH PUBLIC TRUSTEE?

Trust Officers name:	
Clients PTQ#	Trust Location:
Phone #s:	Fax #:
Notes:	

CLIENTS PERSONAL BANKING DETAILS

Bank:	
Branch & Address:	
Account Name:	
BSB Number:	Account Number:

Does this person have any Centrelink or SPER Debts?

☐ Centrelink ☐ SPER ☐ Not known ☐ other_____

Medical information

List all medical conditions:

_____
_____
_____
_____
_____
_____
_____
_____

Current medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Does the client have any infections including MRSA, VRE etc.:_____

Does the client have any allergies?

Food:_____

Medication:_____

Does the client have diabetes: □ Yes □ No

Do they suffer from depression? □ Yes □ No

(If yes, is this being treated and how, please attach)

Do they have memory loss? □ Yes □ No

Do they suffer from: □ Acquired Brain injury □ Intellectual disability

Mobility/Sight/Hearing

Level of mobility:

□ Mobile □ Wheelie Walker □ Walking stick □ Wheelchair

Do they have vision impairment?

□ No

□ Yes: _____

Do they have a hearing impairment?

□ No

□ Yes:

Continence

Do they have: □ Bladder Incontinence □ Bowel Incontinence

Hygiene

Can they attend to their own personal Hygiene? □ Yes □ No

Are they able to feed themselves? □ Yes □ No

Important

Is there any history of behaviours?

□ Aggression- physical □ Aggression – Verbal □ Self Harming

When was the last episode (details)?

_____

What are the triggers (if known)?_____

Is there a history of Drug/Alcohol abuse?

□ Drugs, Last taken _____

What Drugs were abused_____

□ Alcohol, Last taken:_____

How much alcohol was consumed:_____

Is the client a smoker?

□ No

□ Yes, how many a day _____

What do they smoke _____

Is the client at risk of absconding (the facility is a rural setting of 40 acres)? _____

Are they able to live within the community in a shared room? □ Yes □ No

If not please state reasons:_____

Is the client under an involuntary treatment order? □ Yes □ No

(If yes please include contact details)

Does this client have or had any convictions? □ Yes □ No

(If yes, please provide details)

Date requiring Accommodation_____

Does this client require counselling? □ Yes □ No

If yes what counselling is required: _____

What Community services does the client currently access:

□ Disability Services Queensland (DSQ) □ Centacare □ Home & Community Care (HACC)

□ Endeavour □ Mental Health □ Alcoholics Anonymous □ Other_____

Any other information that you think is important for us to know about the client?

_____

_____

_____

_____

_____

Thank you for filling in this form, it will help us to plan for the arrival of the client and best serve his/her needs.

Please email this form to the below contact information.

Colleen Noble – Placement Coordinator

0499 779 877

Email: placements@beaumontcare.com.au

Wamuran Park Home

Beaumont Care

60 Ziviani Road, Wamuran, QLD 4512

Phone 07 54 966 503

Kathy Bryant – Service Manager

kathybryant@beaumontcare.com.au

Website: www.wamuranparkhome.com.au

"our residents are special and our personnel, key"