AGED AND DISABILITY SERVICES
CLIENT INTAKE REFERRAL FORM

PLEASE PRINT ALL DETAILS CLEARLY

PLEASE COMPLETE THIS FORM AND SUBMIT TO NORTHSIDE COMMUNITY SERVICE:

Email: ncsintake@northside.asn.au

In person: 2 Rosevear Place, Dickson ACT 2602

Post: Att Intake Officer:

Po Box 453, Dickson ACT 2602

Fax: Att Intake Officer:

02 6257 5993

Date of Referral: _____ / _____ / _____

REFERRER INFORMATION

Full name of person submitting referral: _____

Organisation / Relationship to referral: _____

Contact number of Referrer: _____

Email address: _____

GENERAL INFORMATION

Has this person consented to this referral? Y ☐ N ☐

**Please note, referral cannot be accepted without consent*

Does the person being referred have a functional disability / medical condition, or care for someone who does? Y ☐ N ☐

Is this condition likely to be ongoing? Y ☐ N ☐ I don't know ☐ Does this person have a carer? Y ☐ N ☐

Name of person being referred: _____

Date of birth: _____ / _____ / _____

Residential address: _____

Contact number: (h): _____ (m): _____

Name of carer: _____

Contact number: (h): _____ (m): _____

Name of Emergency Contact (if different from Referrer and/or Carer): _____

Contact number: (h): _____ (m): _____

Relationship to person being referred: _____

Does this person live alone? yes ☐ with carer ☐ with family ☐ with others ☐ unknown ☐

Does the person identify as Aboriginal or Torres Strait Islander? Aboriginal ☐ Torres Strait Islander ☐ both ☐ neither ☐ not stated/ inadequately described ☐

Language spoken at home: _____ Interpreter required? Y ☐ N ☐

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WHAT SERVICES ARE REQUIRED

Home and Community Care Services:

- ☐ Domestic Assistance
- ☐ Community Transport
- ☐ Case Management
- ☐ Volunteer Assistance
- ☐ Pantry Bus Run
- ☐ Personal Care
- ☐ Shopping Bus
- ☐ Social Groups
- ☐ Shopping Assistance
- ☐ Assistance and Care with Housing for the Aged

Brokerage / Private Services:

- ☐ Domestic Assistance
- ☐ Shopping Support
- ☐ Personal Care
- ☐ Other: _____

Other NCS Services:

- ☐ Majura Men's Shed
- ☐ Energy Efficiency Scheme

Additional information:

What is preventing the person from completing daily living tasks? (e.g. medical conditions, disabilities):

_____

_____

_____

Is this person receiving any other services or support from another organisation? Y ☐ N ☐ unknown ☐

If yes, please describe: _____

_____

_____

Does this person receive any unpaid support from a family member or friend? Y ☐ N ☐ unknown ☐

If yes, please describe: _____

_____

_____

Are there any risks or concerns that Northside Community Service should be aware of? (e.g. concerns regarding mental health, environmental, behavioural, current drug and alcohol issues, memory issues)

Please include any other information that may be important to this referral:

Office Use Only:

Date referral received: _____ / _____ / _____ Name of receiving staff member: _____

Notes: