Registration Form – 2 Recipients

Confidentiality & Privacy Agreement

The information you provide may help us to support you in your caring role. Some of these questions we are required to ask by the Government to help plan and improve services. We will not pass on any identified information without your consent.

Do you give permission for us to disclose information to other agencies to enable us to provide services to support you? Carer: ☐ Yes ☐ No Care Recipients: ☐ Yes ☐ No

Do you consent to us contacting you in the future to take part in surveys, research or evaluation projects?
Carer: ☐ Yes ☐ No Care Recipients: ☐ Yes ☐ No

You can see our Privacy and Confidentiality policy on our website: www.carersupport.org.au

Please note, you can withdraw your permission at any time by contacting registrations@carersupport.org.au or phoning (08) 8379 5777.

NAME OF PERSON COMPLETING THE FORM:
If not filling out form for self – agency of person completing form: Phone number:

****** Please complete all sections of the form ******

CARER DETAILS	**Title:** Select Mr/Mrs/Miss/Ms
First Name: **Surname:**	
Preferred Name:	
DOB: / / **Gender:** ☐male ☐female ☐other	
Address:	
Suburb: **Post code:**	
Council:	
Postal (if diff):	
Telephone: (h) **(w)**	
(m)	
Email:	
Living arrangements: ☐living alone ☐living with others ☐living with family (includes spouse)	
Accommodation setting: ☐own home/purchasing ☐private rental ☐independent living unit ☐public rental ☐supported accommodation ☐other	
Country of birth:	
Main language spoken at home:	
Indigenous status: ☐Not indigenous ☐Aboriginal ☐Torres Strait Islander ☐Prefer not to say	
Department of Veterans Affairs card status: ☐Not a DVA card holder ☐Gold Card ☐White Card ☐Other DVA card	
Employment status: ☐Full time ☐Part time ☐Casual ☐Seasonal ☐Not in paid employment	
Where did you hear about Carer Support?/Source of referral? Select or write below	
Relationship of Carer to Care Recipient 1:	
Relationship of Carer to Care Recipient 2:	

EMERGENCY CONTACTS
Please nominate people who can be contacted and who may make decisions on your behalf if Carer Support is unable to contact you.

EMERGENCY CONTACT 1 (if carer not available):
First name:
Surname:
Address:

Phone:
Mob: Wk:
Relationship to carer:

Is this person aware that they have been nominated? ☐

EMERGENCY CONTACT 2 (if carer not available):
First name:
Surname:
Address:

Phone:
Mob: Wk:
Relationship to carer:

Is this person aware that they have been nominated? ☐

Emergency response – How do you want us to respond if a care recipient doesn't answer the door for a scheduled service?

Please note: if Carer Support has concerns over a client's wellbeing because they fail to answer the door, in some instances we may contact the emergency contact(s) you nominate and/or police. In some circumstances we may also call an ambulance to attend. Please be advised that Carer Support does not provide funding for ambulance attendance.

Is there a **key safe** at either care recipient's home? ☐Yes
Would you like to provide us with the code in case of emergency? Code(s):

Staying in touch

Carer Support produces the Sharing Sheet, a quarterly publication to keep out clients informed about our services. It contains valuable information about respite, events, groups and more. Please let us know how you would like to receive the Sharing Sheet:

☐ Via email *(ensure email address has been provided)*
☐ Via post

Would the carer like **regular supportive calls** from one of our volunteers? ☐ Yes ☐ No

DETAILS: FIRST CARE RECIPIENT	**Title:** Select Mr/Mrs/Miss/Ms
First Name: **Surname:**	
Preferred Name:	
DOB: / / **Gender:** ☐male ☐female ☐other	
Address:	
Suburb: **Post code:**	
Council:	
Postal (if diff):	
Telephone: (h) **(w)**	
(m)	
Email:	
Living arrangements: ☐living alone ☐living with others ☐living with family (includes spouse)	
Accommodation setting: ☐own home/purchasing ☐private rental ☐independent living unit ☐public rental ☐supported accommodation ☐other	
Country of Birth:	
Main Language spoken at home:	
Indigenous status: ☐Not indigenous ☐Aboriginal ☐Torres Strait Islander ☐Prefer not to say	
Department of Veterans Affairs card status: ☐Not a DVA card holder ☐Gold Card ☐White Card ☐Other DVA card	
Employment Status: ☐Full time ☐Part time ☐Casual ☐Seasonal ☐Not in paid employment	
Primary Diagnosis/Disability: Select or write below	
Does the first care recipient have dementia? ☐Yes ☐Suspected, but not diagnosed ☐No Comments:	
Does the first care recipient have an NDIS plan? ☐Yes ☐No	
GP Details for First Care Recipient	
Dr:	
Address:	
Ph:	

CARING ROLE ASSESSMENT:
CARER AND FIRST CARE RECIPIENT

Time spent caring in a typical week:
☐Under 20 hrs ☐20 – 40 hrs ☐over 40 hrs

In a typical week, what does the carer do for the CR?
- ☐ Personal care (eg. showering and dressing)
- ☐ Housework
- ☐ Transport
- ☐ Managing finances
- ☐ Meal Preparation
- ☐ Shopping
- ☐ Feeding (assisting client/care recipient to eat)
- ☐ Continence management
- ☐ Transfers (assisting with getting in/out of chairs/cars etc)
- ☐ Medication administration
- ☐ Emotional support
- ☐ Daily routine support
- ☐ Behaviour support/management
- ☐ Advocacy
- ☐ Liaison with agencies
- ☐ Phone contact with the client/care recipient
- ☐ ALL OF THE ABOVE

Does the carer have a disability/diagnosis of their own?
- ☐ No
- ☐ Yes Select or write below
- ☐ Prefer not to say

Does the carer have any of the following?

☐Difficulties or stress relating to their caring role
Please specify:

☐Health conditions of their own
Please specify:

☐Goals relating to their caring role or access of support services
Please specify:

☐Any other details not recorded elsewhere
Comments:

☐Does the carer drive?

What is the main reason for your registering as a carer?
- ☐ To access respite in case of emergency
- ☐ To access respite now
- ☐ To make use of Carer Support's groups and activities
- ☐ Other (Please provide details):

DETAILS: FIRST CARE RECIPIENT

Please provide additional details of care recipient's diagnoses and care needs, including any secondary/other diagnoses:

What is the first care recipient's level of need:

Assistance is needed:

☐ Occasionally
☐ 1-2 times per day
☐ 2-6 times per day
☐ Regularly throughout the day

Please indicate what daily tasks the first care recipient requires assistance with:

	Independent	With Some Help	Dependent	Comments
Walking/ mobility	☐	☐	☐	☐4 wheel walker ☐Walking Stick ☐Walking frame ☐Scooter/gopher ☐Wheelchair (manual) ☐Wheelchair (electric)
Transferring (getting in/out of chairs/bed/ cars etc)	☐	☐	☐	If yes, how much do they weigh? Do they need 2 people to assist with transfers?
Showering	☐	☐	☐	
Getting dressed	☐	☐	☐	
Using Toilet	☐	☐	☐	
Managing Continence	☐	☐	☐	☐urine ☐faecal ☐both ☐continence products in use
Eating and drinking	☐	☐	☐	☐PEG feed or similar? Please give details ☐Special dietary requirements, please specify:
Medications	☐	☐	☐	☐ Dosette ☐ Webster pack
Housework	☐	☐	☐	
Meal Preparation	☐	☐	☐	
Transport	☐	☐	☐	☐can drive ☐can use public transport
Shopping	☐	☐	☐	
Managing finances	☐	☐	☐	
ALL OF THE ABOVE	☐	☐	☐	

Does the FIRST CARE RECIPIENT have any of the following?

☐ Risk of falls
☐ Wandering
☐ Aggressive behaviour (verbal)
☐ Aggressive behaviour (physical)
☐ Restlessness or agitation
☐ Constant supervision required
☐ Emotional support required
☐ Seizures
☐ Chest pains
☐ Disorientation
☐ Sleep disturbance
☐ Hearing impairment
☐ Vision impairment
☐ Diabetes, (please select): ☐ insulin ☐ tablets ☐ diet
☐ Depressive symptoms
☐ Memory problems or confusion
Comments:

☐ Difficulty communicating
Comments:

☐ Mental illness, diagnosed? ☐ Yes ☐ No
Comments:

☐ Challenging behaviour
Comments (please include details of specific triggers and behaviour management strategies):

☐ **Allergies**
Please specify:

☐ **Hazards in the home**
Please specify:

- ☐ Indoor smoker(s)
- ☐ Outdoor smoker(s)
- ☐ Dog(s)
- ☐ Cat(s)

☐ Support worker preference, please select:

- ☐ Male worker
- ☐ Female worker

Please specify any other requirements:

OTHER SERVICES FOR FIRST CARE RECIPIENT:

Has the first care recipient had any *assessments*?

☐ ACAT, approved for:
- ☐ LOW CARE ☐ HIGH CARE
- ☐ Home Care Package Level 1-2
- ☐ Home Care Package Level 3-4

☐ Regional Assessment Team (RAS)
MAC referral code
Service Type
☐ NDIS Assessment
☐ Disability SA Assessment

Date Assessed (if known): / /
☐ Awaiting assessment – Assessment date (if known): / /
Comments:

Is the first care recipient, or the carer in their caring role for this recipient, currently *receiving any other services*, including services funded by Domiciliary Care, Disability SA, NDIS or a Home Care package?:

☐ No other services
☐ Domiciliary Care
☐ Commonwealth Home Support Service
☐ Home Care Package, Level: ☐ level 1-2 ☐ level 3-4
☐ Council Services
☐ **NDIS Plan**
☐ Disability SA
☐ Palliative Care
☐ Community Mental Health Services
☐ Clinical Mental Health Services
☐ Other services
Please provide details about type of assistance, who is providing it, how often etc.

Does the first care recipient, or the carer in their caring role for this recipient, receive any other informal supports from family/friends etc?

DETAILS: SECOND CARE RECIPIENT	**Title:** Select Mr/Mrs/Miss/Ms
First Name: **Surname:**	
Preferred Name:	
DOB: / / **Gender:** ☐male ☐female ☐other	
Address:	
Suburb: **Post code:**	
Council:	
Postal (if diff):	
Telephone: (h) **(w)**	
(m)	
Email:	
Living arrangements: ☐living alone ☐living with others ☐living with family (includes spouse)	
Accommodation setting: ☐own home/purchasing ☐private rental ☐independent living unit ☐public rental ☐supported accommodation ☐other	
Country of Birth:	
Main Language spoken at home:	
Indigenous status: ☐Not indigenous ☐Aboriginal ☐Torres Strait Islander ☐Prefer not to say	
Department of Veterans Affairs card status: ☐Not a DVA card holder ☐Gold Card ☐White Card ☐Other DVA card	
Employment Status: ☐Full time ☐Part time ☐Casual ☐Seasonal ☐Not in paid employment	
Primary Diagnosis/Disability: Select or write below	
Does the second care recipient have dementia? ☐Yes ☐suspected, but not diagnosed ☐No Comments:	
Does the second care recipient have an NDIS plan? ☐Yes ☐No	
GP Details for Second Care Recipient	
Dr:	
Address:	
Ph:	

CARING ROLE ASSESSMENT:
CARER AND SECOND CARE RECIPIENT

Time spent caring in a typical week:
☐Under 20 hrs ☐20 – 40 hrs ☐over 40 hrs

In a typical week, what does the carer do for the CR?

- ☐ Personal care (e.g. showering and dressing)
- ☐ Housework
- ☐ Transport
- ☐ Managing finances
- ☐ Meal Preparation
- ☐ Shopping
- ☐ Feeding (assisting client/care recipient to eat)
- ☐ Continence management
- ☐ Transfers (assisting with getting in/out of chairs/cars etc.)
- ☐ Medication administration
- ☐ Emotional support
- ☐ Daily routine support
- ☐ Behaviour support/management
- ☐ Advocacy
- ☐ Liaison with agencies
- ☐ Phone contact with the client/care recipient
- ☐ ALL OF THE ABOVE

DETAILS: SECOND CARE RECIPIENT

Please provide additional details of the second care recipient's diagnoses and care needs, including any secondary/other diagnoses:

What is the second care recipient's level of need:

Assistance is needed:

☐ Occasionally
☐ 1-2 times per day
☐ 2-6 times per day
☐ Regularly throughout the day

Please indicate what daily tasks the second care recipient requires assistance with:

	Independent	With Some Help	Dependent	Comments
Walking/ mobility	☐	☐	☐	☐4 wheel walker ☐Walking Stick ☐Walking frame ☐Scooter/gopher ☐Wheelchair (manual) ☐Wheelchair (electric)
Transferring (getting in/out of chairs/bed/ cars etc.)	☐	☐	☐	If yes, how much do they weigh? Do they need 2 people to assist with transfers?
Showering	☐	☐	☐	
Getting dressed	☐	☐	☐	
Using Toilet	☐	☐	☐	
Managing Continence	☐	☐	☐	☐urine ☐faecal ☐both ☐continence products in use
Eating and drinking	☐	☐	☐	☐PEG feed or similar? Please give details ☐Special dietary requirements, please specify:
Medications	☐	☐	☐	☐ Dosette ☐ Webster pack
Housework	☐	☐	☐	
Meal Preparation	☐	☐	☐	
Transport	☐	☐	☐	☐can drive ☐can use public transport
Shopping	☐	☐	☐	
Managing finances	☐	☐	☐	
ALL OF THE ABOVE	☐	☐	☐	

Does the SECOND CARE RECIPIENT have any of the following?

☐ Risk of falls
☐ Wandering
☐ Aggressive behaviour (verbal)
☐ Aggressive behaviour (physical)
☐ Restlessness or agitation
☐ Constant supervision required
☐ Emotional support required
☐ Seizures
☐ Chest pains
☐ Disorientation
☐ Sleep disturbance
☐ Hearing impairment
☐ Vision impairment
☐ Diabetes, (please select): ☐ insulin ☐ tablets ☐ diet
☐ Depressive symptoms
☐ Memory problems or confusion
Comments:

☐ Difficulty communicating
Comments:

☐ Mental illness, diagnosed? ☐ Yes ☐ No
Comments:

☐ Challenging behaviour
Comments (please include details of specific triggers and behaviour management strategies):

☐ **Allergies**
Please specify:

☐ **Hazards in the home**
Please specify:

- ☐ Indoor smoker(s)
- ☐ Outdoor smoker(s)
- ☐ Dog(s)
- ☐ Cat(s)

☐ Support worker preference, please select:

- ☐ Male worker
- ☐ Female worker

Please specify any other requirements:

OTHER SERVICES FOR SECOND CARE RECIPIENT:

Has the second care recipient had any *assessments*?

☐ ACAT, approved for:
- ☐ LOW CARE ☐ HIGH CARE
- ☐ Home Care Package Level 1-2
- ☐ Home Care Package Level 3-4

☐ Regional Assessment Team (RAS)
- MAC referral code
- Service Type

☐ NDIS Assessment
☐ Disability SA Assessment

Date Assessed (if known): / /
☐ Awaiting assessment – Assessment date (if known): / /
Comments:

Is the second care recipient, or the carer in their caring role for this recipient, currently *receiving any other services*, including services funded by Domiciliary Care, Disability SA, NDIS or a Home Care package?

☐ No other services
☐ Domiciliary Care
☐ Commonwealth Home Support Service
☐ Home Care Package, Level: ☐ level 1-2 ☐ level 3-4
☐ Council Services
☐ **NDIS Plan**
☐ Disability SA
☐ Palliative Care
☐ Community Mental Health Services
☐ Clinical Mental Health Services
☐ Other services
Please provide details about type of assistance, who is providing it, how often etc.

Does the second care recipient, or the carer in their caring role for this recipient, receive any other informal supports from family/friends etc.?

Please post completed form to Carer Support at: 770 South Rd, Glandore SA 5037,
OR scan and email it to registrations@carersupport.org.au

Phone: 1800 052 222 or (08) 8379 5777 **Fax:** (08) 8297 4086

Office Use only:

COORDINATOR
Referral to Carer Support's support team:
☐ Yes ☐ No
Welcome pack requested:
☐ Yes ☐ No

ADMIN
☐ Entered on TCM
☐ Care plan entered on TCM
☐ Welcome pack sent

Care Plan: