

## 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](http://www.carersupport.org.au)

Please note, you can withdraw your permission at any time by contacting [registrations@carersupport.org.au](mailto:registrations@carersupport.org.au) or phoning (08) 8433 9555.

**Are you filling out this form on behalf of someone else?**  Yes  No

If yes, please provide your contact details. **Name and agency:**

**Phone:**

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

<b>EMERGENCY CONTACTS</b>
<b>Please nominate people who can be contacted and who may make decisions on your behalf if Carer Support is unable to contact you.</b>
<b>EMERGENCY CONTACT 1 (if carer not available):</b>
<b>First name:</b>
<b>Surname:</b>
<b>Address:</b>
<b>Phone:</b>
<b>Mob:</b>
<b>Relationship to carer:</b>
<b>Wk:</b>
<b>Is this person aware that they have been nominated?</b> <input type="checkbox"/>
<b>EMERGENCY CONTACT 2 (if carer not available):</b>
<b>First name:</b>
<b>Surname:</b>
<b>Address:</b>
<b>Phone:</b>
<b>Mob:</b>
<b>Relationship to carer:</b>
<b>Wk:</b>
<b>Is this person aware that they have been nominated?</b> <input type="checkbox"/>
<b>Emergency response – How do you want us to respond if a care recipient doesn't answer the door for a scheduled service?</b>
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 <b>key safe</b> at either care recipient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like to provide us with the code in case of emergency? Code(s):
<b>Staying in touch</b>
Carer Support produces the Sharing Sheet, a quarterly publication to keep our 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:
<input type="checkbox"/> Via email ( <i>ensure email address has been provided</i> )
<input type="checkbox"/> Via post
Would the carer like <b>regular supportive calls</b> from one of our volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

<b>CARING ROLE ASSESSMENT: CARER AND FIRST CARE RECIPIENT</b>
<b>Time spent caring in a typical week:</b>
<input type="checkbox"/> Under 20 hrs <input type="checkbox"/> 20 – 40 hrs <input type="checkbox"/> over 40 hrs
In a typical week, what does the carer do for the CR?
<input type="checkbox"/> Personal care (eg. showering and dressing)
<input type="checkbox"/> Housework
<input type="checkbox"/> Transport
<input type="checkbox"/> Managing finances
<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Shopping
<input type="checkbox"/> Feeding (assisting client/care recipient to eat)
<input type="checkbox"/> Continence management
<input type="checkbox"/> Transfers (assisting with getting in/out of chairs/cars etc)
<input type="checkbox"/> Medication administration
<input type="checkbox"/> Emotional support
<input type="checkbox"/> Daily routine support
<input type="checkbox"/> Behaviour support/management
<input type="checkbox"/> Advocacy
<input type="checkbox"/> Liaison with agencies
<input type="checkbox"/> Phone contact with the client/care recipient
<input type="checkbox"/> ALL OF THE ABOVE
<b>Does the carer have a disability/diagnosis of their own?</b>
<input type="checkbox"/> No
<input type="checkbox"/> Yes Select or write below
<input type="checkbox"/> Prefer not to say
<b>Does the carer have any of the following?</b>
<input type="checkbox"/> Difficulties or stress relating to their caring role Please specify:
<input type="checkbox"/> Health conditions of their own Please specify:
<input type="checkbox"/> Goals relating to their caring role or access of support services Please specify:
<input type="checkbox"/> Any other details not recorded elsewhere Comments:
<input type="checkbox"/> Does the carer drive?
<b>What is the main reason for your registering as a carer?</b>
<input type="checkbox"/> To access respite in case of emergency
<input type="checkbox"/> To access respite now
<input type="checkbox"/> To make use of Carer Support's groups and activities
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 4 wheel walker <input type="checkbox"/> Walking Stick <input type="checkbox"/> Walking frame <input type="checkbox"/> Scooter/gopher <input type="checkbox"/> Wheelchair (manual) <input type="checkbox"/> Wheelchair (electric)
Transferring (getting in/out of chairs/bed/cars etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much do they weigh? Do they need 2 people to assist with transfers?
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> urine <input type="checkbox"/> faecal <input type="checkbox"/> both <input type="checkbox"/> continence products in use
Eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PEG feed or similar? Please give details <input type="checkbox"/> Special dietary requirements, please specify:
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dosette <input type="checkbox"/> Webster pack
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> can drive <input type="checkbox"/> can use public transport
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Managing finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ALL OF THE ABOVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**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?

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

<b>CARING ROLE ASSESSMENT: CARER AND SECOND CARE RECIPIENT</b>
<b>Time spent caring in a typical week:</b>
<input type="checkbox"/> Under 20 hrs <input type="checkbox"/> 20 – 40 hrs <input type="checkbox"/> over 40 hrs
In a typical week, what does the carer do for the CR?
<input type="checkbox"/> Personal care (e.g. showering and dressing)
<input type="checkbox"/> Housework
<input type="checkbox"/> Transport
<input type="checkbox"/> Managing finances
<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Shopping
<input type="checkbox"/> Feeding (assisting client/care recipient to eat)
<input type="checkbox"/> Continence management
<input type="checkbox"/> Transfers (assisting with getting in/out of chairs/cars etc.)
<input type="checkbox"/> Medication administration
<input type="checkbox"/> Emotional support
<input type="checkbox"/> Daily routine support
<input type="checkbox"/> Behaviour support/management
<input type="checkbox"/> Advocacy
<input type="checkbox"/> Liaison with agencies
<input type="checkbox"/> Phone contact with the client/care recipient
<input type="checkbox"/> 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
<b>Walking/mobility</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 4 wheel walker <input type="checkbox"/> Walking Stick <input type="checkbox"/> Walking frame <input type="checkbox"/> Scooter/gopher <input type="checkbox"/> Wheelchair (manual) <input type="checkbox"/> Wheelchair (electric)
<b>Transferring (getting in/out of chairs/bed/cars etc.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much do they weigh? Do they need 2 people to assist with transfers?
<b>Showering</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Getting dressed</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Using Toilet</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Managing Continence</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> urine <input type="checkbox"/> faecal <input type="checkbox"/> both <input type="checkbox"/> continence products in use
<b>Eating and drinking</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PEG feed or similar? Please give details <input type="checkbox"/> Special dietary requirements, please specify:
<b>Medications</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dosette <input type="checkbox"/> Webster pack
<b>Housework</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Meal Preparation</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Transport</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> can drive <input type="checkbox"/> can use public transport
<b>Shopping</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Managing finances</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ALL OF THE ABOVE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**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 (or drop in) to Carer Support, 770 South Road, Glandore SA 5037  
OR scan and email it to [registrations@carersupport.org.au](mailto:registrations@carersupport.org.au)**

**Phone: 1800 052 222 or (08) 8433 9555 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: