

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 Recipient/Client: 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 Recipient/Client: 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) 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:

CARER DETAILS	Title: Select Mr/Mrs/Miss/Ms
First Name:	
Surname:	
Preferred Name:	
DOB: / /	Gender:
Address:	
Suburb:	
Post code:	
Council:	
Postal (if diff):	
Telephone: (h)	
(w)	
(m)	
Email:	
Living arrangements:	
<input type="checkbox"/> living alone <input type="checkbox"/> living with others	
<input type="checkbox"/> living with family (includes spouse)	
Accommodation setting:	
<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	
Country of Birth:	
Main Language spoken at home:	
Indigenous status:	
<input type="checkbox"/> Not indigenous <input type="checkbox"/> Aboriginal	
<input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Prefer not to say	
Department of Veterans Affairs card status:	
<input type="checkbox"/> Not a DVA card holder	
<input type="checkbox"/> Gold Card <input type="checkbox"/> White Card <input type="checkbox"/> Other DVA card	
Employment Status:	
<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	
Where did you hear about Carer Support?/Source of referral? Select or write below	
Relationship of Carer to Care Recipient:	

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:
Relationship to carer:
Wk:
Is this person aware that they have been nominated? <input type="checkbox"/>
EMERGENCY CONTACT 2 (if carer not available):
First name:
Surname:
Address:
Phone:
Mob:
Relationship to carer:
Wk:
Is this person aware that they have been nominated? <input type="checkbox"/>
Emergency response – How do you want us to respond if the client/care recipient doesn't answer the door for a scheduled service?
Please note: if Carer Support has concerns over the client's wellbeing because they fail to answer the door, in some instances we may contact either the emergency contact 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 the client/care recipient's home? <input type="checkbox"/>
Yes
Would you like to provide us with the code in case of emergency? Code:
Staying in touch
Carer Support produces the Sharing Sheet, a quarterly publication to keep our clients informed about our services. The Sharing Sheet 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 (please ensure email address has been provided)
<input type="checkbox"/> Via post
Would the carer like regular supportive calls from one of our volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

CARING ROLE ASSESSMENT:
Time spent caring in a typical week:
<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
Does the carer have a disability/diagnosis of their own?
<input type="checkbox"/> No
<input type="checkbox"/> Yes Select or write below
<input type="checkbox"/> Prefer not to say
Does the carer have any of the following:
<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?
What is the main reason for your registering as a carer?
<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 Details:

CARE RECIPIENT DETAILS

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

What is the 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 client/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 CLIENT/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 CARER/CLIENT/CARE RECIPIENT:

Has the client/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 carer or client/care 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 carer or client/care 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

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: