Richmond Wellbeing

CARER SUPPORT REFERRAL FORM

CARER SUPPORT SERVICES

CARER SUPPORT REFERRAL FORM

A CARER provides support to a person who is living with a mental health challenge and requires support to sustain their caring role.

Complete this form where a client is identified as a primary Carer who is experiencing stress or financial, emotional or lifestyle pressures as a result of their caring role.

If **Residential Carer Respite** is required, please contact Intake.

REFERRER DETAILS (if applicable)

Name: Agency / Position:

Postal Address: Postcode:

Phone: Email:

APPLICANT TO COMPLETE

1. Your Details

First Name: Family Name: Date of Birth:

Preferred Name: Ethnicity:

Gender: ☐ Male ☐ Female ☐ LGBTIQ+ ☐ Other ☐ Decline to answer

Address: Postcode:

Phone: Mobile: Email:

Aboriginal: ☐ Yes ☐ No Torres Strait origin: ☐ Yes ☐ No

Culturally and Linguistically Diverse: ☐ Yes ☐ No Country of Birth:

Main Language spoken: ☐ English ☐ Other:

Interpreter required: ☐ Yes ☐ No Visa Status:

Living Situation: ☐ Living Independently ☐ Living with family member/carer
☐ Homeless ☐ Other:

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Defacto

Children: ☐ Yes ☐ No Occupation:

Source of Income: ☐ Age Pension ☐ Carer Allowance
☐ Disability Pension ☐ Department of Veteran's Affairs
☐ Family Assistance ☐ Unemployment
☐ Youth Allowance ☐ Paid work
☐ Other (please specify):

Hold a DVA Card? ☐ Yes ☐ No If yes, what type? ☐ Gold ☐ White ☐ Other

2. Caring Arrangement

Relationship to Care Recipient?

Date caring role commenced: or Years:

Care level: ☐ High ☐ Moderate ☐ Low

Care need: ☐ Primary ☐ Other ☐ Not stated / Inadequately described

Co-resident carer? ☐ Yes ☐ No

Time spent caring per week: ☐ Less than 20 hrs ☐ 20 – 39 hrs ☐ 40 hrs or more

3. Current Carer Supports

Formal Services (received by Carer):

- ☐ Not receiving services
- ☐ Receiving a package
- ☐ Receiving one or more services
- ☐ Not stated / Inadequately described

Informal Supports (received by Carer):

- ☐ Father
- ☐ Husband / Male partner
- ☐ Other male relative
- ☐ Mother
- ☐ Wife / Female partner
- ☐ Other female relative
- ☐ Daughter
- ☐ Daughter-in-law
- ☐ Male friend/neighbour
- ☐ Son
- ☐ Son-in-law
- ☐ Female friend / neighbour
- ☐ No informal support
- ☐ Not stated/Inadequately described

4. Care Recipient Details (the person who is being cared for)

Name of Care Recipient:

Diagnosis:

Does the Care Recipient have a Case Manager/Coordinator? ☐ Yes ☐ No

Name: Agency:

Email: Phone: Mobile:

Existing NDIS Plan? ☐ Yes ☐ No NDIS Plan Number: *(Attach plan)*

Formal Services (received by Care Recipient):

- ☐ Not receiving services
- ☐ Receiving a package
- ☐ Receiving one or more services
- ☐ Not stated / Inadequately described

Primary care needs (of the Care Recipient):

FORM CONTINUES ON PAGE 4

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5. Consent

I consent to the disclosing of my personal and health information to Richmond Wellbeing for the purpose of assessing my eligibility recovery support services.

Signature: _____

Date: _____

** If Guardian, provide a copy of your Guardian Order issued by the State Health Tribunal.*

PLEASE COMPLETE FORM & RETURN TO RICHMOND WELLBEING

F (08) 9258 3090

E intake@rw.org.au

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RESPECT CULTURE

TRANSLATING AND INTERPRETING SERVICE

NATIONAL RELAY SERVICE

Quality Improvement Council 'Yes ... we are a QIC accredited organisation'

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INTENTIONALLY

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