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Initial Contact Form

The following information is subject to Care Norfolk Inc. Privacy Principles
This information is strictly confidential and for the use of Care Norfolk Inc. only.

SURNAME:		FIRST NAME(S):	
MALE/FEMALE HIM/HER	DATE OF BIRTH:	AGE:	
ADDRESS:		EMAIL:	
PHONE:		PO Box No:	
Language other than English spoken at home:			
Person making referral:			
Relationship to person referred:			
Has the person being referred consented to this referral being made on their behalf?			☐ Yes ☐ No
Does the person being referred display any challenging behaviours that may provide a risk to our staff when they are in the home? I.e., are they, 1. Agitated or distressed, 2. Displaying threatening or aggressive behaviour, 3. Being verbally aggressive or abusive, 4. Displaying behaviours that are out of character.			☐ Yes ☐ No
Further information:			**Date of initial contact/referral**

1. What assistance would you like from Care Norfolk Inc.

☐ Nursing ☐ Meals ☐ Transport ☐ Flexible respite

☐ Personal care ☐ Social support ☐ Domestic assistance

☐ Home modifications ☐ Home maintenance

2. Why do you think this assistance is needed?

_____

_____

3. Do you have regular contact with the person being referred?

☐ Yes ☐ No ☐ N/A

4. Has it been explained to the person being referred that Care Norfolk Inc. will be in contact with them to discuss this referral?

☐ Yes ☐ No

5. Is the person being referred on another program? ☐ Yes ☐ No ☐ Unsure

If yes, please indicate ☐ MPSHCP ☐ NICHE ☐ HCP ☐ NDIS ☐ Other

Official use only

1. Was contact made with referred person to confirm the referral?

☐ Yes ☐ No ☐ Not needed (self-referral)

2. Emailed/given RAS referral form? ☐ Yes ☐ No

Name: _____ Date:

Signature: _____