Client Referral Form Date of Referral ______/______/__________

This form is to be used to provide preliminary information to Real Community Services for the referral of a client. Further information may be gained through telephone conversation or additional profile documentation to allow progression to acceptance of referral and intake.

For the purposes of this form, any reference to 'client' shall also mean young person or participant

Client Name	
Address	
Referral Contact made by	
Position / Relationship to Client	

Contact Number(s)	
Reason for Referral	
Anticipated Commencement Date	
Specialised Supports: Are there any specialised or primary support needs such as a disability or an acquired brain injury?	
D.O.B. of Client	
What are the anticipated support hours? (Recommended service, days, times, hours per day or week)	

Service/s Funding Type		Budget Amount	

Does the person require assistance or supervision for:	always	most of the time	some of the time	never
a. SELF CARE (washing, dressing, eating, toileting): prompting	1	2	3	4
b. MOBILITY (around the house, public transport, getting in and out of bed/chairs):	1	2	3	4
c. COMMUNICATION (understanding, being understood, controlling emotions to do so):	1	2	3	4

d. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS (making and keeping friends, managing interactions appropriately):	1	2	3	4
e. LEARNING AND APPLYING KNOWLEDGE (new ideas, memory, problem solving)	1	2	3	4
f. GENERAL TASKS AND DEMANDS (understands single/multiple tasks, daily routine, decision making)	1	2	3	4
g. COMMUNITY LIFE (recreation, religion/spirituality):	1	2	3	4
h. DOMESTIC LIFE (meals, housekeeping, shopping):	1	2	3	4
i. FINANCIAL (handling money, money recognition, making purchases, budget; banking)	1	2	3	4

Background *(Care arrangement, relevant familial / historical information, context)*

Behaviours *(Particular Behaviours, Triggers and Strategies to defuse behaviours)*
Identified Risks *(To client, carer and community)*

RCS Office Use Only

Initial Eligibility Assessment:

Does Initial assessment support a decision to proceed?

Yes Proceed Service Capacity Assessment No Decline Referral

Service Capacity Assessment

**** This is to be considered in conjunction with any Support Plan &/or Rehabilitation Program***

• Does the client have specialized support needs?	Yes No
• Would supporting the client necessitate a change in RCS policies or procedures?	Yes No
• Is there sufficient staff currently available to support the client by anticipated start date?	Yes No
• Is there flexibility in the budget should support needs necessitate a change	Yes No

Quotation Provided and Accepted

Yes Proceed to Commencement No Decline Referral

Recommendation by Service Manager to proceed

Yes Forward all documentation to Managing Director No no further action

Referral Decision:
Accept Referral Decline Referral
________________________________ ________/_______/___________
Date