care finder referral form

Thank you for referring your client. To help us understand your client's needs, please complete all sections of this referral form.

Date of referral:	Referrer name:	Referrer phone:
Referrer email:	Referrer's relationship to client:	

Client details			
Title:	Family name:	First name:	Middle name:
Gender:	Date of Birth:	Estimated Date of Birth:	
Address:		Suburb:	
Postcode:	Phone (home):	Phone (mobile):	
Country of birth:		Preferred language:	
Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No ☐ Unsure		Interpreter required: ☐ Yes ☐ No ☐ Unknown	
Is the client a person with disability: ☐ Yes ☐ No ☐ Unsure			
If yes, what is the nature of their disability:			
If yes, is the client a NDIS participant: ☐ Yes ☐ No ☐ Unsure			

Emergency contact		
Name:	Relationship:	Phone:

Referral details	
Is the client eligible for Government funded aged care services?	☐ Yes ☐ No ☐ Unsure
My Aged Care ID number if known:	
Does the client have an Aged Care package?	☐ Yes ☐ No ☐ Unsure
Has the client undergone a RAS or ACAT assessment?	☐ Yes ☐ No ☐ Pending ☐ Unsure
To be eligible for the care finder program, the client needs to be unable to independently interact with My Aged Care (either through the website, via phone through the contact centre or face to face through Services Australia service centre) and does not have any family, friends or other community members who can assist them in navigating My Aged Care services	

Does the client experience one or more of the following challenges?	
• Isolation or no available support person	☐ Yes ☐ No ☐ Unsure
• Communication barriers, including limited health literacy skills	☐ Yes ☐ No ☐ Unsure
• Difficulty processing information to make decisions	☐ Yes ☐ No ☐ Unsure
• Resistance or hesitancy to engage with aged care, institutions, or government for any reason	☐ Yes ☐ No ☐ Unsure
• Their safety is at risk, or they may end up in a crisis	☐ Yes ☐ No ☐ Unsure
Please provide any relevant information that can assist us in supporting your client in the most appropriate manner. Please outline any barriers to accessing My Aged Care and aged care supports as well as any specific challenges facing the client along with existing supports.	

Consent	
I consent to the referral being made on my behalf	
Client signature:	Date:
Referrer signature:	Date:

Marathon Health is committed to protecting your information, and any information we collect is used to facilitate the services we provide to you.

- In providing high-quality services, we collect personal health information and maintain a client record.
- We follow the Australian Privacy Principles (APPs) contained in the Privacy Act 1988 when handling, using and managing personal information.
- The APPs also outline your rights relating to accessing or correcting your personal information.
- We will not sell, transfer, assign or rent your information to any third party without your permission, unless required by law.

Referrer acknowledgement

I have discussed the proposed referral to a health professional with the client and/or authorised representative and am satisfied that the client and/or authorised representative understands the proposed collection, use and disclosure of personal health information and has provided informed consent to the proposed collection, use and disclosure.

Referrer name	*Referrer signature*	*Date*

Phone: 1300 418 223
Email: carefinder@marathonhealth.com.au