

# Consumer Information

If question is irrelevant or information not known, write Not Applicable or NA

test

## Consumer Details

Family Name: \_\_\_\_\_

Sex (circle one) Male Female

Given Names: \_\_\_\_\_

Title (circle one) Mr Mrs Ms Other

Date of Birth dd/mm/yyyy / /

Preferred Name/s: \_\_\_\_\_

## Contact Details

Contact Address (for correspondence, home visits etc)

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Usual Address: (if different from contact address)

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Contact Phone Number/s (tick preferred number) Can leave message? Y or N

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Who the Agency Can Contact if Necessary (eg, case manager, next of kin, carer, guardian, friend, emergency contact)

Person 1 Name: \_\_\_\_\_

Person 2 Name: \_\_\_\_\_

Contact Details:

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Contact Details:

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

## General Practitioner (if no GP, write NA)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## This Page Completed By: (tick one)

- The consumer or someone who represents the consumer (carer, parent or guardian)
- The agency (face-to-face with consumer)
- The agency (other, incl. telephone contact with consumer)

Consumer privacy information brochure provided?  Yes  No

### Office Use Only

Name: \_\_\_\_\_ Designation/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_ Contact number: \_\_\_\_\_

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Sign: \_\_\_\_\_

# Consumer Information

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

## Service Requested

Notes: (including alerts and comments on risks, urgency and access issues)

## Source of Referral

- Record: (1) Self. (2) Family, significant other, friend.  
(3) GP/medical practitioner (community-based).  
(4) Specialist aged or disability assess. team/service (eg. ACAT).  
(5) Comprehensive HACC assessment authority.  
(6) Community nursing service. (7) Hospital (public).  
(8) Psychiatric/mental health service or facility.  
(9) Extended care/rehabilitation facility. (10) Palliative care facility/hospice.  
(11) Government residential aged care facility.  
(12) Aboriginal health service. (13) Carelink centre.  
(14) Other community-based government medical/health service.  
(15) Other government medical/health service.  
(16) Other government community-based services agency.  
(17) Hospital (private). (18) Non-government residential aged care facility.  
(19) Other non-government medical/health service.  
(20) Other non-government community-based service.  
(21) Law enforcement agency.  
(22) Other.

Source of Referral Contact Details:

## Country of Birth

Record: (1) Australia. (2) Other.

If other, specify:

## Indigenous Status

- Record: (1) Aboriginal but not Torres Strait Islander origin.  
(2) Torres Strait Islander but not Aboriginal origin.  
(3) Both Aboriginal and Torres Strait islander origin.  
(4) Neither Aboriginal nor Torres Strait Islander origin.

## Main Language Spoken at Home

Record: (1) English.  
(2) Other.

If other, specify:

## Interpreter Required

Record: (1) Interpreter not needed.  
(2) Interpreter needed.

## Preferred language

(if not spoken English), including sign language, and any required communication devices or special interpreter needs:

## Government Pensioner/ Benefit Status

- Record: (1) Aged Pension.  
(2) Veterans' Affairs Pension.  
(3) Disability Support Pension.  
(4) Carer Payment (pension).  
(5) Unemployment-related benefits.  
(6) Other gov. pension or benefit.  
(7) No gov. pension or benefit.

Card Number:

## DVA Card Status

- Record: (1) No DVA Card.  
(2) Yes Gold Card.  
(3) Yes White Card.  
(4) Yes Other DVA Card.

DVA Card Number:

## Insurance Status

Insurer Name and Card Number:

Medicare Number:

Health Care Card Number:

## Office Use Only

Name:

Designation/Agency:

Sign:

Date:

Contact number:

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Date:

Name:

Sign:

# Summary and Referral Information

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

## Why the Consumer Is Seeking Services

Description of reason for referral as identified by the consumer or referring agency, plus description of other issues as identified by the consumer or in the initial needs identification process:

Notes:

Department of Human Services

16204021



Office Use Only

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Name: \_\_\_\_\_ Designation/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_ Contact number: \_\_\_\_\_

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Date: \_\_\_\_\_ Name: \_\_\_\_\_ Sign: \_\_\_\_\_

# Summary and Referral Information

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## Current Services

Record services used in the last three months

Service	Record contact details or other information as appropriate

Consider all health and community services, including (but not limited to) alternate therapists, aged care, alcohol and drug, community health, counselling, dental care, disability, emergency accommodation, family planning, home care, hospital inpatient, hospital outpatient, hospital emergency, maternal and child health, medical (GP), medical (specialist), men's health, mental health, palliative care, rehabilitation, residential aged care, respite care, self help groups, sexual health, women's health, youth services.

## Initial Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the initial action required.

To be referred to:

Agency/health professional	For	Consumer Consent	Referral Method	Feedback required	Date

**Agency/health professional:** Complete in legible text. If you will be continuing to see the client, include yourself in the list of agencies/professionals for referral

**For:** Record purpose of referral in legible text

**Consumer Consent:** Record: (1) Yes, consumer consents to referral and to sharing of information as specified on consumer consent form. (2) Yes, consumer consents to referral but not to sharing of information. (3) No, consumer has not consented to this referral.

**Referral method:** Record: (1) This form faxed to agency. (2) Letter (copy on file). (3) Electronic. (4) Verbal request, face-to-face or phone call. (5) Other (incl. refer to self).

**Feedback required:** Record: (1) To initial referral agency. (2) To GP. (3) To agency completing INI. (4) To carer/guardian. (4) Other.

**Date:** Record date referral actually made. If no referral actually made, leave blank

### Office Use Only

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Name: \_\_\_\_\_ Designation/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_ Contact number: \_\_\_\_\_

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# Consumer Consent

To Specified Use/Disclosure of Information

Agency Contact Details

To ensure the consumer is able to make an informed decision about consent to the disclosure of their information, the practitioner should:

(✓ tick when completed)

1. Discuss with the consumer the proposed referral to other services/agencies. \_\_\_\_\_
2. Explain that the consumer's information will only be released to these services if the consumer has agreed and advise that the referral for service can still proceed if the consumer does not want information disclosed. \_\_\_\_\_
3. Provide the consumer with information about privacy, such as the brochure *Your Information—It's Private*. \_\_\_\_\_
4. Provide the consumer with a copy of this form, once completed. \_\_\_\_\_

## Section 1: Proposed Information Uses and Disclosures

The following service(s) are recommended. It is also recommended that relevant information is forwarded to the agency(s) that provide these services, in order that consumers receive the best possible care.

Type of Service Examples: – Physiotherapy – Specialist consultant	Name of Agency Examples: – Any agency – Nominated clinic	Type of Information (including limits as applicable) Examples: – All relevant information – Test results only

## Section 2: Record of Consumer Consent

2(A) Written Consumer Consent

Or

2(B) Verbal Consent

2(a)

*My practitioner has discussed with me how, when and why certain information about me may need to be provided to other agencies.*

*I understand the recommendations and I give my permission for the information to be shared as detailed above.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Consumer OR Authorised Representative)

Consumer Name: \_\_\_\_\_

Witnessed: \_\_\_\_\_  
(Practitioner)

Practitioner Name: \_\_\_\_\_

Role: \_\_\_\_\_

2(b)

Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

*I have discussed the proposed referrals with the consumer. I am satisfied that the consumer understands the proposed uses and disclosures, and has provided their informed consent to these.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Practitioner)

Practitioner Name: \_\_\_\_\_

Role: \_\_\_\_\_

Department of Human Services

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Sign: \_\_\_\_\_