

NOARLUNGA VOLUNTEER TRANSPORT SERVICE INC.
REFERRAL / ASSESSMENT FORM
64 and Under

Client Personal Details						
Title		Surname		Given Name		
Preferred Name				Marital Status		
Telephone				Email:		
<i>Property title, if applicable e.g. retirement village</i>						
Address					Post code	
Gender	Male	Female	Date of Birth	/ /	Age	
Aboriginal or ATSI	Yes	No	Has a carer		Yes	No
Country of Birth			Lives with carer		Yes	No
Language spoken at home:			Has non-resident carer		Yes	No
Interpreter required	Yes	No	Carer relationship to client			
			The client is a carer		Yes	No

Carer or Advocate Details						Primary contact
Title		Surname		Given Name		Preferred Name
<i>Property title, if applicable e.g. retirement village</i>						
Address					Post code	
Telephone				Email:		
Gender	Male	Female	Relationship to client			
Country of birth			Language			Interpreter Required: Yes <input type="checkbox"/> No <input type="checkbox"/>

Contact Person						Primary contact	
Title		Surname		Given Name		Preferred Name	
Property title, if applicable e.g. retirement village							
Address						Post code	
Telephone		Email:					
Gender	Male	Female	Relationship to client				

Living & Support Arrangements			
Housing			
Own home	Unit	Private rental	Public tenant
Other (specify)			
Living at home			
Alone	With spouse	With family	
Other (specify)			
Transport			
Car	Public Transport	Community Bus	
Other (specify)		Access Cab vouchers Yes	
Client's GP and ambulance cover			
Name		Telephone number	
Surgery name & address			
Does the client have ambulance cover?		Yes	No

Income						
Does the client get a pension? Yes		No	If Yes, pension number is:			
Type of pension	Aged	Full Part	DVA	Gold White	Other	Other than Aged or DVA
Detail (if required)						

Other Community Support Services Used		
Royal District Nursing Service	Metro Dom Care	Meals on Wheels
Red Cross	Mental Health Services	
Other (specify)		

What informal assistance is available on a regular basis?
e.g. friend, social club, church group

Relevant Health Information

What does the client see as difficulties and/or health problems (e.g. hearing, allergies, eye sight)

How will any of these affect service delivery?

Tasks of daily living

Please circle either an I, WA, D, or NA:

I	represents	“Independent”		
WA	represents	“With Assistance”		
D	represents	“Dependent”		
N/A	represents	“Not applicable”		
Shopping/Banking	I	WA	D	N/A
House work	I	WA	D	N/A
Use of the telephone	I	WA	D	N/A
Transport	I	WA	D	N/A
Communications skills	I	WA	D	N/A
Community access	I	WA	D	N/A
Walking	I	WA	D	N/A

Comments

Equipment used to maintain independence

Home and Safety and Access

Are there any factors about this home that could affect Safety/for access (eg. Dog) by:

Service providers Yes No

Carer

Service Provider

Client Signature

Comment if the client is unable to sign (e.g verbal agreement)

Date / /

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