COMMUNITY REHABILITATION SERVICES
RICHMOND NETWORK
Carroll Centre, Avondale Ave, Lismore
Tel: (02) 6629 4827
Fax:(02) 6629 4535
NNSWLHD-Richmond-IntakeCommunityRehab@health.nsw.gov.au

Health
Northern NSW
Local Health District

Referral Form for Community Rehabilitation Services Richmond Network

Incorporating Day Therapy Services - Lismore, Casino, Evans Head & Ballina

Suitable for clients referred from the Community

CLIENT DETAILS					
MRN:		**DOB:**		**GENDER:**	
SURNAME:				**FIRST NAME:**	
ADDRESS:					
				PHONE:	
ABORIGINAL OR TORRES STRAIT ISLANDER: ❑ **YES** ❑ **NO** ❑ **Not Identified**					
CARER / NEXT OF KIN:				**PHONE:**	
ADDRESS:				**RELATIONSHIP:**	
GP:				**GP PHONE:**	

CURRENT SUPPORT SERVICES IN PLACE (*please tick*)

❑ Home Care Package- ❑Level 1 ❑Level 2 ❑Level 3 ❑Level 4 ❑Waiting List

❑ Commonwealth Home Support Programme (details of service):

_____

❑ NDIS (include details of how plan is managed:

_____

MEDICAL DETAILS	
DIAGNOSIS/INJURY – DATE OF ONSET:	
PRE-EXISTING CONDITIONS:	
REASON FOR REFERRAL:	

Client requires: ❑ Physiotherapy ❑ Occupational Therapy ❑ Social Work ❑ Speech Pathology

CLIENT ELIGIBILITY

❑ **Presents with difficulties in at least <u>TWO</u> of the following functional areas:** (*please tick*)

- ❑ Mobility
- ❑ Communication difficulties
- ❑ Swallowing difficulties
- ❑ Risk of Falls
- ❑ Psychosocial/emotional Wellbeing
- ❑ Home Safety
- ❑ Employment/Recreation/ Leisure
- ❑ Activities of Daily Living e.g. feeding, personal care, domestic duties.

For a person to be suitable for referral they <u>must</u> meet <u>all</u> the following criteria: *(please tick)*

- ❑ *Medically stable*
- ❑ *Has the cognitive capacity to learn*
- ❑ *Aware of referral and willing to engage*
- ❑ *Demonstrates a capacity for improvement*

REFERRER INFORMATION

REFERRED BY:		**DATE/TIME:**	
DESIGNATION:		**CONTACT NO & EMAIL:**	
ORGANISATION:		**SIGNATURE:**	

**** <u>Please attach medical/allied health summaries to referral form if available</u>***