Form D168

VS Referral Form v4.0

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| --- |
| Office Use Only |
| Referral Date:  |       |  Type:  | [ ]  New [ ]  Re | Consent:  | [ ]  Yes [ ]  No |
| Form completed by (if different to referral source):  |       |

|  |
| --- |
| Personal Details  |
| Surname:  |       | Other names:  |       |
|  |
| Male [ ]  Female [ ]  |
|  |
| Address:  |       |
|  |
|       | Postcode:  |       |
|  |
| Phone Number: |       | Mobile:  |       |
|  |
| Work Number:  |        | Email:  |       |
|  |
| Date of Birth: |       | Country of Birth:  |       |
|  |
| Language preferred:  |       | Interpreter required?  | [ ]  Yes [ ]  No  |
|  |
| Is the person of Aboriginal or Torres Strait Islander Origin? | [ ]  No [ ]  Yes, Aboriginal [ ]  Yes, Torres Strait Islander [ ]  Yes, both Aboriginal and Torres Strait Islander |
|  |
| Communication needs:  | [ ]  Large Print [ ]  Braille [ ]  Oral [ ]  Auslan [ ]  Email [ ]  CD |
|  |
| Employment status:  |       |
|  |
| Pension/benefit (type):  |       | DVA Card:  | **[ ]** Yes [ ]  No |
|  |
| Work cover/compensation claim/ other:  |       |
|  |
| Specialist Information |
| GP: |       | Surgery: |       |
|  |
| Address: |       |
|  |
| Phone number:  |       | Fax:  |       |
|  |
| Ophthalmologist:  |       | Phone:  |       |
|  |
| Optometrist: |       | Phone:  |       |
| Next of Kin  |
| Name: |       | Relationship: |       |
|  |
| Phone Number: |        | Mobile: |       |
|  |
| Alternative /Appointment Contact:  |       |
|  |
| For appointment please contact:  | [ ]  Client [ ]  Next of kin [ ]  Other  |       |
| Referral Details |
| Reason for referral:  | [ ]  Orientation & Mobility [ ]  Low Vision Assessment[ ]  Falls Prevention  | [ ]  Neurological Vision Service [ ]  Occupational Therapy [ ]  Physiotherapy  | [ ]  Orthoptics [ ]  Education[ ]  NDIS |
|  |
| Reason for Vision Assessment/Intervention:  |       |
|  |
| Eye condition and cause of vision loss:  |       |
|  |
| Date of incident:  |       |
|  |
| Details of recent eye assessment (attach if available):  |       |
|  |
| Other details:  |       |
|  |  |
| Is the client distressed due to changes in vision? | [ ]  Yes [ ]  No |
|  |
| Has the client had a recent fall/history of falls due to vision? | [ ]  Yes [ ]  No |
|  |
| Is the client able to attend GDA SA/NT clinic at 251 Morphett St Adelaide? | [ ]  Yes [ ]  No |
|  |
| Medical history:  |       |
| Referral Source |
| Name: |       | Position:  |       |
|  |
| Organisation:  |       |
|  |
| Address:  |       |
|  |
| Phone:  |       | Fax:  |       |
|  |
| Email: |       |
|  |

|  |  |
| --- | --- |
| Preferred Contact:  | [ ]  Email [ ]  Phone [ ]  Fax |

|  |
| --- |
| Mobility |
| Mobility Status  | [ ]  Independent  | [ ]  Standby  | [ ]  Assist | [ ]  Not mobile  |
| Current Mobility Aid:  | [ ]  Wheelchair[ ]  Long cane | [ ]  Frame[ ]  ID cane  | [ ]  Walking stick[ ]  Guide Dog  | [ ]  Motorised scooter[ ]  No aids  |
|  |
| Indoors:  |       | Outdoors:  |       |
|  |
| Driver’s License:  | [ ]  Yes [ ]  No | Suspended | [ ]  Yes [ ]  No |
|  |
| Alert Details |
| Is the client performing tasks that could present a safety risk?  | [ ]  Yes [ ]  No |
|  |
| Behavioural considerations? | [ ]  Yes [ ]  No |
|  |
| Environmental considerations? | [ ]  Yes [ ]  No |
|  |
| Details:  |       |
| Inpatient Details (if applicable):  |
| Hospital: |       | Acute /Rehabilitation |       |
|  |
| Ward: |       | Bed number: |       |
|  |  |  |  |
| Admission Date: |       | Estimated date of discharge: |       |
|  |
| Is the client being discharged home alone?  | [ ]  Yes [ ]  No |
| Is vision impacting on ability to engage in rehab program?  | [ ]  Yes [ ]  No |
| Would vision assessment/intervention affect the discharge outcome?  | [ ]  Yes [ ]  No |
| Is the client returning to work/study?  | [ ]  Yes [ ]  No |
| Will the client be providing care for someone else after discharge?  | [ ]  Yes [ ]  No |
| Is the client being discharged to a regional area? | [ ]  Yes [ ]  No |
|  |
| List any other services involved and contact details (if applicable):  |       |
|  |
| Comments:  |       |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| National Disability Insurance Scheme (NDIS) – If Applicable

|  |  |  |
| --- | --- | --- |
| Guide Dogs SA/NT Client Status: | [ ]  New Client | [ ]  Existing Client |
| NDIS Plan Status: | [ ]  No current plan (client seeking pre-planned support) |
|  | [ ]  Plan in place (client wishes to commence NDIS services – complete details below) |

NDIS services requested (include allocated hours/funding, if known):

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| --- |
|       |

|  |  |
| --- | --- |
| NDIS Reference Number: |       |

|  |  |  |
| --- | --- | --- |
| Plan Funds: | [ ]  Self-Managed | [ ]  Agency (MyPlace portal) managed |

|  |  |  |  |
| --- | --- | --- | --- |
|  | [ ]  Plan Manager Provider       | [ ]  Combination | [ ]  Unknown |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Copy of NDIS Plan  | Provided? | [ ]  Yes[ ]  No | Requested? | [ ]  Yes[ ]  No | Details:       |

Appendix One – Home Visiting Risk Assessment

|  |  |
| --- | --- |
| Does the client have any hesitations/concerns in allowing this service into their home?  | [ ]  Yes [ ]  No |
| Is there any potential for or a history of violence or aggression in the household?  | [ ]  Yes [ ]  No |
| Is there anything in regard to the client/others/household that might be a potential risk to anyone visiting the home? | [ ]  Yes [ ]  No |
| Are any other people expected to be present at the time of the visit/service? | [ ]  Yes [ ]  No |
| Are there any special directions needed to get to the clients home? | [ ]  Yes [ ]  No |
| Are the premises easily accessible and visible from the street? | [ ]  Yes [ ]  No |
| Is someone able to readily open the door? | [ ]  Yes [ ]  No |
| Are there any domestic animals on the premises? | [ ]  Yes [ ]  No |
| If so, are they able to be restrained/removed for the visit?  | [ ]  Yes [ ]  No |
| Does the client or others in the household smoke? | [ ]  Yes [ ]  No |
| If so are they able to not smoke during the visit? | [ ]  Yes [ ]  No |

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| If the answer was yes or unknown to any of the questions above please provide further explanation: |
|       |

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| --- |
| Please send/fax this form to:Vision Services Guide Dogs SA/NT251 Morphett StreetAdelaide SA 5000Fax: (08) 8203 8332clients@guidedogs.org.aufor enquiries please call: (08) 8203 8333 |