ASPIRE
AGED CARE BY LDK

** Indicates mandatory field.*

Aspire Aged Care Referral Form

Greenway Views, 260 Soward Way Greenway ACT
Ph: 1300 535 000 hello@LDK.com.au or sharon.scott@LDK.com.au

Referral discussed with | **Date of Contact**

Date

Client Details

Full Name & Title*

Address

Email* | Telephone*

Date of Birth | Age* | Gender

Lives Alone? Yes ☐ No ☐ Specify

Home Owner ☐ Private Residence ☐ Public Rental ☐ Other

Primary contact: Client ☐ Other ☐ Specify

Contact Name | EPOA Yes ☐ No ☐

Relationship to Client | Telephone

Income Type | DVA (card colour)

Country of Birth | Aboriginal/TSI Yes ☐ No ☐

Method of Communication: Verbal English ☐ Verbal Non-English ☐ Non-Verbal Specify

Type of residency*: Respite ☐ Permanent ☐ Both ☐

Reason for referral*:

Relevant past medical history:

Does the client have any current support services in place? ○ Yes ○ No

CHSP	○	Home Care Package Level 1	○	Home Care Package Level 2	○
Home Care Package Level 3	○	Home Care Package Level 4	○	DVA	○
Other (eg: NDIS)					

If Yes please specify the type(s) of support and service providers. Please also identify the level of informal supports received by client.*

Date of admission to hospital | Discharge date

GP / Specialist | Telephone

Geriatrician | Telephone

Care Needs: Please indicate the patients level of function	Low *(Level 1)* Minimal / Stand by	Moderate *(Level 2)* Assistance of 1	High *(Level 3)** Assistance of 2
Bathing	○ Low	○ Moderate	○ High
Dressing	○ Low	○ Moderate	○ High
Eating	○ Low	○ Moderate	○ High
Mobility	○ Low	○ Moderate	○ High
Toileting / Incontinence	○ Low	○ Moderate	○ High
SPC	○ Yes	○ No	
IPC	○ Yes	○ No	
Meals:	○ Independent	○ Assist/Prompt	○ Full Assistance
Medication:	○ Independent	○ Assist/Prompt	○ Full Assistance
Is the client taking psychotropic medication?		○ Yes	○ No
Assistance with transport required		○ Yes	○ No
Has an OT Assessment been done in this current hospital admission? *(Please attach a copy of the OT Assessment)*		○ Yes	○ No

Are there any assistive aids in place? *(i.e. shower chair, walking frame)*

Shower Chair	○	4 X Wheeled Walker	○	Sara Stedy	○
Toilet Riser	○	Wheelchair	○	Stand Up Lifter	○
Commode	○	Electric Wheelchair	○	Hoist/Sling Lifter	○
Walking Frame	○	Electric/Hospital Bed	○	Other	○

If other, please specify:

Is the client a high falls risk?	○ Yes	○ No
Does the client have dementia?	○ Yes	○ No
Does the client have Parkinson's?	○ Yes	○ No
Does the client have wandering behaviours?	○ Yes	○ No

Are there any cognitive/behavioral issues that may impact on other residents/staff?? ○ Yes ○ No

If Yes, please give details

Please state additional information that could assist us to provide appropriate support/s for this client, such as any special requirements due to cultural background, religion, financial disadvantage, male/female support worker etc.

Referrer Details

Agency or Health Provider*

Name*

Phone Number* Contact email

Signature Date

This consent authorises LDK to use information in this referral for the purpose of planning, organising and delivering services, as requested.

Written Consent from the client/guardian *(name)*: Client ☐ Guardian ☐ Name

OR

Verbal Consent From *(name)*: Client ☐ Guardian ☐ Name

Verbal Consent obtained by: *(Name)*

Signature Date