# Referral Form

Carers WA offers a range of services to family members and friends who are providing unpaid care and support to someone with an illness or disability.

If you are a carer and would like to register with Carers WA, please call **1800 422 737**. The Carer Gateway will direct your call to Carers WA.

Agencies, service providers and health professionals can submit a carer referral through this form, however they must have client consent.

All referrals must have the **Carer Details** and **Referrer Details** completed.

For **Youth Referrals** please also complete the relevant sections below before submitting.

Questions with \* are mandatory and must be completed for referral to be actioned.

**Submission**

Once you have completed this Referral Form, please save this document on your computer and email it to **referral@carerswa.asn.au**.

## Carer Details

|  |  |
| --- | --- |
| **First Name\*:** Click here to enter text. | **Last Name\*:** Click here to enter text. |

|  |  |
| --- | --- |
| **Date of Birth\*:** DD/MM/YYYY | **Gender:** Click here to enter text. |
| **Phone:** Click here to enter text. |
| **Email:** Click here to enter text. |

|  |
| --- |
| **Street Address:** Click here to enter text. |
| **Suburb:** Click here to enter text. | **State:** Click here to enter text. |
| **Postcode:** Click here to enter text. |  |

|  |
| --- |
| **Indigenous status:**  |
| Aboriginal[ ]  | Torres Strait Islander[ ]  | Both[ ]  | Neither[ ]  |
| **Country of birth:** Click here to enter text. |
| **Main language:** Click here to enter text. |

**Does the client require an interpreter?**

|  |  |  |
| --- | --- | --- |
| Yes[ ]  | No[ ]  | **If yes, which dialect?** Click here to enter text. |

|  |
| --- |
| **Relationship of carer to care recipient:**  |
| Parent[ ]  | Offspring[ ]  | Spouse/Partner[ ]  | Sibling[ ]  |
| Grandparent[ ]  | Grandchild[ ]  | Extended Family[ ]  | Friend/Other[ ]  |

|  |  |
| --- | --- |
| **Full name of care recipient** | Click here to enter text. |

**Reason for referral\***

|  |
| --- |
| Click here to enter text. |

Continued on the next page.

## Referrer Details

|  |  |
| --- | --- |
| **First Name\*:** Click here to enter text. | **Last Name\*:** Click here to enter text. |
| **Organisation/agency name\*:** Click here to enter text. |
| **Position title:** Click here to enter text. |
| **Phone:** Click here to enter text. | **Email:** Click here to enter text. |

## Consent

Please note: Referrers are required to obtain consent from their clients before submitting this form. The information provided on this form will remain strictly confidential.(Please click to check the box).\*

|  |  |  |
| --- | --- | --- |
| **I (the referrer) have received consent from the client to share client information with Carers WA\*** | **Yes**[ ]  | **No**[ ]  |
| **I (the referrer) have received consent from the client for Carers WA to contact the client to complete an intake and assessment\*** | **Yes**[ ]  | **No**[ ]  |

## Youth Referrals Only

Consent is required for Carers WA to process referrals for young people under the age of 18.

**Details of parent/guardian**

|  |  |
| --- | --- |
| **First Name:** Click here to enter text. | **Last Name:** Click here to enter text. |
| **Relationship to child:** Click here to enter text. |
| **Phone:** Click here to enter text. | **Email:** Click here to enter text. |

(Please click to check the box).

|  |  |  |
| --- | --- | --- |
| **I (the referrer) declare that I have received consent from the parent/guardian to submit this form to Carers WA and for Carers WA to contact the parent/guardian to complete an intake and assessment.** | **Yes**[ ]  | **No**[ ]  |
| **The young person is under 18 years old, I have received consent from the young person (NOT the parent/ guardian as yet) and I would like to chat with the Youth Needs Assessment Officer to explore potential support options.** | **Yes**[ ]  | **No**[ ]  |