

# PCP Initial Needs Identification CONSUMER INFORMATION

If question is irrelevant or information not known, write Not Applicable or NA

## Consumer details

Family Name: \_\_\_\_\_

Given Names: \_\_\_\_\_

Date of birth dd/mm/yyyy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Sex (circle one) Male Female

Preferred Name/s: \_\_\_\_\_

Title (circle one) Mr Mrs Ms Other \_\_\_\_\_

## Contact details

Contact Address (for correspondence, home visits etc)

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Usual Address (if different from contact address)

\_\_\_\_\_ (number) \_\_\_\_\_ (street)

\_\_\_\_\_ (suburb/locality) \_\_\_\_\_ (postcode)

Record Agency Assigned Consumer Identifier (initial contact agency)

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or affix label here

Contact phone number/s (tick preferred number)	Can leave message? Y or N
Home	
Work	
Mobile	
Fax	
Email address	

## Who the agency can contact if necessary

(eg, case manager, next of kin, carer, guardian, friend, emergency contact)

Person 1 Name	Person 2 Name
Contact details _____ (number) _____ (street) _____ (suburb/locality) _____ (postcode) Phone: _____ Relationship to client	Contact details _____ (number) _____ (street) _____ (suburb/locality) _____ (postcode) Phone: _____ Relationship to client

## General Practitioner (if no GP, write NA)

Name:

Address:

Phone:

Fax:

Email:

## This page completed by

(tick one)

The consumer or someone who represents the consumer (carer, parent or guardian)

The agency (face to face with consumer)

The agency (other, incl. telephone contact with consumer)

Consumer privacy information brochure provided? Yes No

## Office Use Only

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Name \_\_\_\_\_ Designation/Agency \_\_\_\_\_

Sign \_\_\_\_\_ Date \_\_\_\_\_ Contact number \_\_\_\_\_

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded

Date:

Name:

Sign:

# PCP Initial Needs Identification CONSUMER INFORMATION

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## Service requested

Notes, including alerts and comments on risks, urgency and access issues

## Source of Referral

- Record: (1) Self.
- (2) Family, significant other, friend.
- (3) GP/medical practitioner – community based.
- (4) Specialist aged or disability assess team/service (eg. ACAT).
- (5) Comprehensive HACC assessment authority
- (6) Community nursing service.
- (7) Hospital (public).
- (8) Psychiatric/mental health service or facility.
- (9) Extended care/rehabilitation facility.
- (10) Palliative care facility/hospice.
- (11) Government residential aged care facility.
- (12) Aboriginal health service.
- (13) Carelink centre.
- (14) Other community-based government medical/health service.
- (15) Other government medical/health service.
- (16) Other government community-based services agency.
- (17) Hospital (private).
- (18) Non government residential aged care facility.
- (19) Other non government medical/health service.
- (20) Other non government community-based service.
- (21) Law enforcement agency.
- (22) Other.

Source of Referral Contact Details

## Country of Birth

Record: (1) Australia. (2) Other.

If other, specify \_\_\_\_\_

## Indigenous Status

- Record: (1) Aboriginal but not Torres Strait Islander Origin.
- (2) Torres Strait Islander but not Aboriginal Origin.
- (3) Both Aboriginal and Torres Strait islander Origin.
- (4) Neither Aboriginal nor Torres Strait Islander Origin.

Record Agency Assigned Consumer Identifier (initial contact agency)

\_\_\_\_\_

or affix label here

## Main Language Spoken at Home

Record: (1) English. (2) Other.

If other, specify \_\_\_\_\_

## Interpreter Required

Record: (1) Interpreter not needed. (2) Interpreter needed

Preferred language, (if not spoken English) including sign language, & any required communication devices or special interpreter needs

## Government Pensioner/Benefit Status

- Record: (1) Aged Pension
- (2) Veterans' Affairs Pension
- (3) Disability Support Pension
- (4) Carer Payment (pension)
- (5) Unemployment related benefits
- (6) Other gov pension or benefit
- (7) No gov pension or benefit

Card Number

## DVA Card Status

- Record: (1) No DVA Card
- (2) Yes – Gold Card
- (3) Yes – White Card
- (4) Yes - Other DVA Card

DVA Card Number

## Insurance Status

Insurer Name and Card Number

Medicare Number

Health Care Card Number

## Office Use Only

Name \_\_\_\_\_ Designation/Agency \_\_\_\_\_

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Sign \_\_\_\_\_ Date \_\_\_\_\_ Contact number \_\_\_\_\_

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The information on this form has been superseded

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Sign: \_\_\_\_\_