

## Community Based Support Intake Form

If you require **emergency respite**  
 please call **Carer Gateway** on **1800 422 737**

### About the carer

First name	
Last name	
Preferred name	
Date of birth	
Gender	
Address	
Email	
Contact number	
Employment status	
Carer status (e.g. primary carer/secondary carer/young carer)	
Relationship to person you care for	
Country of birth	
Language spoken at home	
Disability, impairment or condition of the person you care for	
Indigenous status	
Alternative carer name	
Alternate carer phone number	

### About the referrer

<b>Referrer's name</b>	
<b>Referrer's contact number</b>	
<b>Referrer's email</b>	
<b>Does the referrer want to be contacted about the outcome</b>	Yes No
<b>Background information about the referral</b>	
<b>Reason for referral</b>	

## Consents

<b>Consent to share your de-identified information (i.e. no names shared)</b>	Yes No Date:
<b>Carer has consent to act on behalf of the person they care for? (i.e. organise and set up services etc.)</b>	Yes No Date:
<b>Consent to have personal information stored in Your Side database</b>	Yes No
<b>Consent to participate in follow-up research, surveys and evaluation</b>	Yes No

## About the care recipient

<b>First name</b>	
<b>Last name</b>	
<b>Preferred name</b>	
<b>Type of funded plan/package (NDIS / My Aged Care) (if applicable)</b>	
<b>Date of birth</b>	
<b>Address</b>	Street: Suburb: State:            Postcode:

Contact details	
Disability/condition	
Home Assessment completed	Yes No
Details on Home Assessment	
Discharge plan	

### Other comments

Once you have filled out this referral form, please email it to: [intake@yourside.org.au](mailto:intake@yourside.org.au)