



GREEK ORTHODOX COMMUNITY OF SA INC.  
**COMMUNITY CARE SERVICES**  
**REFERRAL**

Phone: (08) 7088 0500 Fax: (08) 8245 5586

DATE OF REFERRAL: \_\_\_\_/\_\_\_\_/\_\_\_\_

Priority Ranking:  
(Office use Only)

Low

Medium

High

Title: \_\_\_\_\_ Given Names: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

DOB: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Language spoken: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (Mob) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Gender: Male ☐ Female ☐

GP Name: \_\_\_\_\_ Telephone \_\_\_\_\_

GP Address: \_\_\_\_\_

Pension Type: \_\_\_\_\_ CRN \_\_\_\_\_ Access Cab: Yes ☐ No ☐ Unknown ☐

Ambulance Cover: Yes ☐ No ☐ Unknown ☐ Number \_\_\_\_\_

**CARER INFORMATION**

Is there a Carer : Yes ☐ No ☐ Primary Contact : Yes ☐ No ☐

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B: ...../...../.....

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_

Carer Residency Status: Co- Resident Carer ☐ Non- Resident Carer ☐ Not Stated ☐

**ADDITIONAL INFORMATION**

Accommodation: Home Owner ☐ Private tenant ☐ Public tenant ☐ Unit ☐ Other ☐ \_\_\_\_\_

Living Arrangements: Lives alone ☐ Lives with family ☐ Lives with spouse ☐ Lives with others ☐ Not stated ☐

Other Services involved: \_\_\_\_\_

**MEDICAL INFORMATION**Hearing loss: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound / Wears Aids: Yes ☐ No ☐Vision loss: ☐ Mild ☐ Moderate ☐ Severe (Legal) ☐ Total / Eye Condition: \_\_\_\_\_Medical Condition / Disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**REFERRAL INFORMATION**Reason for referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_OHS&W: Does the Client have pets? ☐ Y ☐ N Comments: \_\_\_\_\_Services requested: \_\_\_\_\_  
\_\_\_\_\_Which program is sought: Seniors Groups (Filoxenia): ☐ Carer Support Program ☐Social Support: ☐ Emergency Relief Program ☐ In – Home Support: ☐ Limani Dementia Respite Program: ☐

Referring Person (Name): \_\_\_\_\_ Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

How did you learn about GOC's Programs: \_\_\_\_\_

Feedback to Referral Person: Yes ☐ No ☐Client Aware of Referral: Yes ☐ No ☐

REFERRAL TAKEN BY: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Use only**Privacy Statement Read / Sent: Yes ☐ No ☐ Privacy Statement Date Advised: \_\_\_\_/\_\_\_\_/\_\_\_\_Previous GOC Record: Yes ☐ No ☐ Program \_\_\_\_\_**ACTION TAKEN:**

• ALLOCATED TO COORDINATOR: (Name) \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

• PLACED ON WAIT LIST: YES ☐ NO ☐ WAIT LIST LETTER SENT: YES ☐ NO ☐ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_• FOLLOW UP CALL RE: WAIT LIST: DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_