Carer Registration Form

Confidentiality & Privacy Agreement

The information you provide may help us to support you in your caring role. The Government requires us to ask some of these questions to help plan and improve services. We will not pass on any identified information without your consent.

Do you give permission for us to disclose information to other agencies to enable us to provide services to support you in your caring role? Carer: ☐ Yes ☐ No Care Recipient: ☐ Yes ☐ No

Do you consent to us contacting you in the future to take part in surveys, research or evaluation projects?

Carer: ☐ Yes ☐ No Care Recipient: ☐ Yes ☐ No

You can see our Privacy and Confidentiality policy statement on our website: www.carersact.org.au

Please note, you can withdraw your permission at any time by contacting respite.coordinators@carersact.org.au or phoning 1800 052 222.

****** Please complete all sections of the form ******

Date Completed: ___/___/___

YOUR DETAILS	**Title:** SelectMr/Mrs/Miss/Ms ☐Are you using a pseudonym?
First Name:	**Last Name:**
Preferred Name:	
DOB: / /	**Gender:** ☐male ☐female ☐intersex/indeterminate ☐prefer not to say **Do you identify as LGBTI?** ☐yes
Address:	
Suburb:	**Post code:**
Postal (if different):	
Telephone: **(h)**	**(w)** **(m)**
Email:	
Living arrangements: ☐Single and living alone ☐couple ☐living with family ☐living with others ☐Prefer not to say	
Accommodation setting: ☐own home/purchasing ☐private rental ☐independent living unit ☐public rental ☐supported accommodation ☐other ☐Prefer not to say	
Country of Birth:	**Main Language spoken at home:**
Other Main Language:	**Interpreter required:** ☐
Indigenous status: ☐Not indigenous ☐Aboriginal ☐Torres Strait Islander ☐Prefer not to say	
Government Pension status: ☐No Pension/Benefit ☐Aged ☐DVA ☐Carer Payment ☐Carer Allowance ☐Disability Support ☐Other	
Department of Veterans Affairs card status: ☐Not a DVA card holder ☐ DVA Gold Card ☐ DVA White Card ☐Other DVA card	
Employment Status: ☐Full time ☐Part time ☐Casual ☐Seasonal ☐Not in paid employment	
Where did you hear about Carers ACT?	

What is your relationship to the person you care for?:

☐ Spouse/partner ☐ Son/Daughter ☐ Parent/Guardian ☐ Sibling ☐ Other **Details:**

Do you provide the most assistance to the person who needs care? ☐ Yes -Primary Carer ☐ No - Secondary Carer

How long have you been caring? ☐ 6 months or more ☐ less than 6 months **Approximate start date:**

EMERGENCY CONTACTS

Please nominate people who can be contacted and who may make decisions on your behalf if Carers ACT is unable to contact you.

EMERGENCY CONTACT 1/ ALTERNATE CARER (if carer not available):

First name: **Surname:**

Phone: **Mob:** **Wk:**

Relationship to carer:

Is this person aware that they have been nominated? ☐

EMERGENCY CONTACT 2 (if carer not available):

First name: **Surname:**

Phone: **Mob:** **Wk:**

Relationship to carer:

Is this person aware that they have been nominated? ☐

Emergency response – How do you want us to respond if the care recipient doesn't answer the door for a scheduled service?

Please be advised that if Carers ACT has concerns over the client's wellbeing because they fail to answer the door, in some instances we may contact either the emergency contact you nominate and/or police.
In some circumstances, we may also call an ambulance to attend. Please be advised that Carers ACT does not provide funding for ambulance attendance.

Would you like to receive our newsletter/events notices and other updates?

☐ Yes ☐ No Bulk Emails/mail outs (Note: Carers ACT may invite you to participate in surveys and provide feedback on our services from time to time)

Would you like to receive regular supportive calls? ☐ Yes ☐ No

CARER DETAILS - CARING ROLE ASSESSMENT:

How many people do you care for: (if you wish to register more than 1 person being cared for please complete for each person)

Time spent caring in a typical week:

☐ Under 20 hrs ☐ 20 – 40 hrs ☐ over 40 hrs

In a typical week, what do you do for the person(s) being cared for?

- ☐ Personal care (eg. showering and dressing)
- ☐ Housework
- ☐ Transport
- ☐ Managing finances
- ☐ Meal Preparation
- ☐ Shopping
- ☐ Feeding (assisting care recipient to eat)
- ☐ Continence management
- ☐ Assisting with getting in/out of chairs/cars etc
- ☐ Medication administration
- ☐ Emotional support
- ☐ Daily routine support
- ☐ Behaviour support/management
- ☐ Advocacy
- ☐ Liaison with agencies
- ☐ Phone contact with the care recipient
- ☐ All of the above

Do you have difficulties or stress relating to your caring role? Details:

Do you have health conditions of your own?

☐ None ☐ Physical ☐ Chronic Health ☐ Mental health ☐ Sensory/speech
☐ Intellectual/Learning ☐ Other please specify:

Have you been assessed for, or are you receiving any support services for yourself? Eg ACAT, NDIS, Home Help
Please specify:

Do you have any goals relating to your caring role? Please specify:

Please provide any other details not recorded elsewhere. Comments:

How do you access services?

☐ Has own transport ☐ Use public transport ☐ Needs assistance with transport

What is your main reason for registering as a carer?

- ☐ To access respite now
- ☐ To access respite in case of emergency
- ☐ To make use of Carers ACT's groups and activities
- ☐ To find out how Carers ACT can assist me
- ☐ Other **Details:**

CARE RECIPIENT DETAILS

DETAILS OF THE PERSON BEING CARED FOR	**Title:** SelectMr/Mrs/Miss/Ms ☐Is using pseudonym?
First Name:	**Surname:**
Preferred Name:	
DOB: / /	**Gender:** ☐male ☐female ☐other
Address:	
Suburb:	**Post code:**
Postal (if diff):	
Telephone: (h)	**(w)** **(m)**
Email:	
Living arrangements: ☐living alone ☐living with others ☐living with family (includes spouse)	
Accommodation setting: ☐own home/purchasing ☐private rental ☐independent living unit ☐public rental ☐supported accommodation ☐other	
Country of Birth:	
Main Language spoken at home:	**Other Main Language:**
Indigenous status: ☐Not indigenous ☐Aboriginal ☐Torres Strait Islander ☐Prefer not to say	
Government Pension status: ☐No Pension/Benefit ☐Aged ☐DVA ☐Carer Payment ☐Carer Allowance ☐Disability Support ☐Other	
Department of Veterans Affairs card status: ☐Not a DVA card holder ☐Gold Card ☐White Card ☐Other DVA card	
Employment Status: ☐Full time ☐Part time ☐Casual ☐Seasonal ☐Not in paid employment	
Primary Diagnosis/Disability: Select or write below ☐Physical: (please specify) ☐Intellectual/learning: (please specify) ☐Sensory/speech: (please specify) ☐Mental Health: (please specify) ☐Other: (please specify)	
Does the care recipient have dementia? ☐Yes ☐suspected, but not diagnosed ☐No Comments:	
Does this person have a Power of Attorney? ☐yes Name of POA:	
GP Details	
Dr:	
Address:	
Ph:	

CARE RECIPIENT DETAILS

Please provide additional details of care recipient's diagnoses and care needs, including any secondary/other diagnoses:

What is the care recipient's level of need/supervision?

☐ Low ☐ Medium ☐ High

Please indicate what daily tasks the recipient requires assistance with:

	Independent	With Some Help	Dependent	Comments
Walking/ mobility	☐	☐	☐	☐4 wheel walker ☐Walking Stick ☐Walking frame ☐Scooter/gopher ☐Wheelchair (manual) ☐Wheelchair (electric)
Transferring (getting in/out of chairs/bed/ cars etc)	☐	☐	☐	If yes, how much do they weigh? Do they need 2 people to assist with transfers?
Showering	☐	☐	☐	
Getting dressed	☐	☐	☐	
Using Toilet	☐	☐	☐	
Managing Continence	☐	☐	☐	☐bladder ☐bowel ☐both ☐continence products in use
Eating and drinking	☐	☐	☐	☐PEG feed or similar? Please give details ☐Special dietary requirements, please specify:
Medications	☐	☐	☐	☐ Dosette ☐ Webster pack
Housework	☐	☐	☐	
Meal Preparation	☐	☐	☐	
Transport	☐	☐	☐	☐can drive ☐can use public transport
Shopping	☐	☐	☐	
Managing finances	☐	☐	☐	
ALL OF THE ABOVE	☐	☐	☐	

Does the CARE RECIPIENT have any of the following?

☐ Risk of falls
☐ Wandering
☐ Aggressive behaviour (verbal)
☐ Aggressive behaviour (physical)
☐ Restlessness or agitation
☐ Constant supervision required
☐ Emotional support required
☐ Seizures
☐ Chest pains
☐ Disorientation
☐ Sleep disturbance
☐ Hearing impairment
☐ Vision impairment
☐ Diabetes, (please select): ☐ insulin ☐ tablets ☐ diet
☐ Depressive symptoms
☐ Memory problems or confusion
Comments:

☐ Difficulty communicating
Comments:

☐ Mental illness, diagnosed? ☐ Yes ☐ No
Comments:

☐ Challenging behaviour
Comments (please include details of specific triggers and behaviour management strategies):

☐ **Allergies**
Please specify:

☐ **Hazards in the home**
Please specify:

☐ Indoor smoker(s)
☐ Outdoor smoker(s)
☐ Dog(s)
☐ Cat(s)
☐ Other Pets
Please specify:
Support worker preference, please select:
☐ Male ☐ Female ☐ No preference
Please specify any other requirements:

OTHER SERVICES FOR CARE RECIPIENT:

Has the care recipient had any *assessments*?

☐ Regional Assessment Team (RAS)
☐ ACAT, approved for:
- ☐ Level 1
- ☐ Level 2
- ☐ Level 3
- ☐ Level 4
- ☐ Residential Respite
- ☐ Residential Permanent Placement

☐ NDIS Assessment

Date Assessed (if known): / /
☐ Awaiting assessment – Assessment date (if known): / /
Comments:

Is the care recipient currently *receiving any other services*, including services funded by NDIS or a Home Care package?:

☐ No other services
☐ Commonwealth Home Support Program
☐ Home Care Package, Level:
- ☐ Level 1
- ☐ Level 2
- ☐ Level 3
- ☐ Level 4

☐ NDIS Plan
☐ Palliative Care
☐ Mental Health Services
☐ Clinical Mental Health Services
☐ Other services
Please provide details about type of assistance, who is providing it, how often etc.

Does the carer or care recipient receive any other informal supports from family/friends etc? Details:

Please post completed form to Carers ACT at: 2/80 Beaurepaire Crescent, Holt, 2615 ACT
OR scan and email it to respite.coordinators@carersact.org.au

Phone: 1800 052 222 or (02) 6296 9900

Additional Notes