



# Queensland Lifestyle Services Inc.

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## CONSUMER SERVICE REFERRAL PROFILE FORM

### Excluding Page 13,

ALL PAGES MUST BE FULLY COMPLETED BY INDIVIDUAL WITH DISABILITY AND / OR THE PERSON MAKING THE REFERRAL BEFORE BEING FORWARDED TO QUEENSLAND LIFESTYLE SERVICES INC.

(please tick which service you are referring to, can be more than one)

- A. Temporary Response Service (TRS) Emergency Respite
- B. Mobile Service
- C. Residential Support Program (RSP)

### CONFIDENTIALITY

Completed forms remain confidential and only confidentialised data is passed on to the Funding Body as required – details of individual services or consumers will not be released without consent of the individual client or their delegated advocate.

### AGENCY MISSION

QLS mission is to

Promote lifestyle choices for people with a disability by commitment to

- The continual development and provision of services
- People's participation in community
- Involvement by the community for the pursuit of quality lifestyles and social justice.

Name of Person (person with a disability) \_\_\_\_\_ DOB \_\_\_\_\_

The above person with disability agrees and consents to this referral ... Signature of Person \_\_\_\_\_

### Person Filling Out This Referral Form

Contact Name

Mr Mrs Miss Ms

Given Name

Surname

Signature

Title

Position or Status

STD Code Telephone No.

Date

Mobile No.

# CONSUMER PROFILE

THE FOLLOWING INFORMATION THAT IS PROVIDED IS TO COVER  
THE PERSON WITH A DISABILITY.

Date  /  /

Mr Mrs Miss Ms

Given Name

Surname

Date of Birth  /  /

Age

Sex Male

Female

Religion (if any) \_\_\_\_\_

Cultural Needs (if any-  
including institutionalisation) \_\_\_\_\_

Address \_\_\_\_\_

Post Code \_\_\_\_\_

Landline Phone No. ( ) \_\_\_\_\_

Mobile Phone No. \_\_\_\_\_

Disability Support Pension No. \_\_\_\_\_

Aged Pension No. \_\_\_\_\_

Medicare No. \_\_\_\_\_

Other: \_\_\_\_\_

General Practitioner \_\_\_\_\_ Ph: \_\_\_\_\_

Referral Source \_\_\_\_\_

Contact Name \_\_\_\_\_

Referral Source \_\_\_\_\_

Phone No. ( ) \_\_\_\_\_

Mobile Phone No. \_\_\_\_\_

Who is the person with a disability preferred Advocate?

Name \_\_\_\_\_

Contact Number \_\_\_\_\_

A. Is this person a client of the Public Trustee? Yes  No

Is this person a client of the Adult Guardian? Yes  No

B. How many regular on-going support hours does this person receive weekly from the referral source and / or other community support groups, etc?

Hours \_\_\_\_\_

C. Does this person have a "Registration of Need" application with Department of Communities Disability Services?

Yes

No

D. Does this person have an Adult Lifestyle Package, Family Support Package or Post School Option Package or HACC Funded Package?

Yes  No  If yes, type: \_\_\_\_\_

Total Hours In Package \_\_\_\_\_ Hours per week \_\_\_\_\_

E. What other agencies or supports are involved with this person?

- a). \_\_\_\_\_  
b). \_\_\_\_\_  
c). \_\_\_\_\_

F. Have you applied and received funds from any of these Agencies for Emergency Funds to cover this particular situation?

- |  |     |                          |    |                          |
|--|-----|--------------------------|----|--------------------------|
| 1) Other TRS agency, i.e. Cairns                                 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2) Department of Communities Disability Services (One-off Grant) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3) Cootharinga At Risk Program                                   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4) Cootharinga Ageing Carers Program                             | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5) Public Trustee  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6) Blue Nurses   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7) Commonwealth Carelink / and C'wealth Respite Centre           | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Other _____  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If you applied and did not receive any funds, what was the reason given at the time of application?  
\_\_\_\_\_

If you were successful how many hours were you given? Hours \_\_\_\_\_  
When do they run out? \_\_\_\_\_

G. Has the agency applying, for Emergency Respite Funds been given also a One-off Grant from Department of Communities Disability Services to cover Emergency Respite for their particular client Group connected to Lifestyle Packages or Family Supports?

Yes  No

If YES, are there any funds available for this client? Yes  No

If NO, please give the reason given at the time,  
\_\_\_\_\_

#### Emergency Respite (Temporary Response Service Applicants Only)

H. How many Emergency TRS Support Hours are being applied for? *Please circle which amount, should funds be available*  
10    20    30    40    50    60    70    80    90    100

I. What specific support tasks are required in this instance?

Functional Support	<input type="checkbox"/>	Community Access/Linking	<input type="checkbox"/>
Appropriate Accompanying	<input type="checkbox"/>	Mobility	<input type="checkbox"/>

J. Are Support Workers employed for TRS activities cleared by the:

- |   |     |                          |    |                          |
|---|-----|--------------------------|----|--------------------------|
| (a) Suitability (Blue) Card <i>(if the client is a child)</i> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| (b) Disability Services Criminal History Screening            | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

**This is a requirement for access to the funds.**



# Service User Data

Service Type ID

TRS

Mobile

RSP

(Number to be allocated by QI/SLI, for processing finances and general data for the Funding Body)

1a. Surname

1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>	7 <sup>th</sup>	8 <sup>th</sup>	9 <sup>th</sup>	10 <sup>th</sup>

1b. Given Name

--	--	--	--	--	--	--	--	--	--

1c. Date of Birth

d	d	m	m	y	y	y	y

1d. Is the service user's date of birth an **estimate**?

Yes

No

1e. What is the service user's **sex**?

Male

Female

2. Is the service user of **Aboriginal** or **Torres Strait Islander origin**?

Aboriginal but not Torres Strait Island origin

Torres Strait Islander but not Aboriginal origin

Both Aboriginal and Torres Strait Islander origin

Neither Aboriginal nor Torres Strait Islander origin

3. In which **country** was the service user **born**?

Australia

Italy

England

Philippines

New Zealand

Scotland

Viet Nam

India

China

South Africa

(excl SARs & Taiwan)

*If other country please specify* \_\_\_\_\_

4. Does the service user require **interpreter services**?

Yes – for spoken language other than English

Yes – for non-spoken communication

No

5. What is the service user's most effective **method of communication**?

- Spoken language (effective)
- Sign language (effective)
- Other effective non-spoken communication  
- e.g. Canon Communicator, Compic, etc
- Little, or no effective communication
- Child aged under 5 years (not applicable)

This item is considered 'not applicable' to young children. Hence children 0-4 years should be coded as 'Child aged under 5 yrs.'

6. Does the service user usually **live alone** or **with others**?

- Live alone
- Lives with family
- Lives with others

'Usually' means 4 or more days per week on average.

The service user's living arrangements must relate to the same place described in residential setting (see question 8)

7. What is the **POSTCODE** of the service user's usual residence?

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The service user's postcode must relate to their residential setting (see question 8).

8. What is the service user's usual **residential setting**?

- Private residence   
- e.g. includes public and private rental
- Residence within an Aboriginal / Torres Strait Island community
- Domestic-scale supported living facility   
-e.g. group homes
- Supported accommodation facility   
-e.g. hostels, supported residential services or facilities
- Boarding house / private hotel
- Independent living unit within a retirement village
- Residential aged care facility   
- nursing home or aged care hostel
- Psychiatric / mental health community care facility
- Hospital
- Short term crisis, emergency or transitional accommodation   
- e.g. night shelters, refuges, hostels for the homeless, halfway houses
- Public place / temporary shelter
- Queensland Public Housing
- Other

The type of physical accommodation the person usually resides in ('usually' means 4 or more days per week on average)

9. What are the service user's **primary** and **other significant disability group(s)**?

**a. Primary Disability Group**

*(Tick 1 box only)*

**b. Other Significant Disability Group(s)**

*(Tick all other significant disabilities)*

- |                          |   |                          |
|--------------------------|---|--------------------------|
| <input type="checkbox"/> | Intellectual  | <input type="checkbox"/> |
| <input type="checkbox"/> | Specific learning/ADD - other than Intellectual             | <input type="checkbox"/> |
| <input type="checkbox"/> | Autism - including Asperger's syndrome                      | <input type="checkbox"/> |
| <input type="checkbox"/> | Physical  | <input type="checkbox"/> |
| <input type="checkbox"/> | Acquired brain injury                                       | <input type="checkbox"/> |
| <input type="checkbox"/> | Neurological - including Epilepsy & Alzheimer's Disease     | <input type="checkbox"/> |
| <input type="checkbox"/> | Deafblind - dual sensory                                    | <input type="checkbox"/> |
| <input type="checkbox"/> | Vision  | <input type="checkbox"/> |
| <input type="checkbox"/> | Hearing   | <input type="checkbox"/> |
| <input type="checkbox"/> | Speech  | <input type="checkbox"/> |
| <input type="checkbox"/> | Psychiatric   | <input type="checkbox"/> |
| <input type="checkbox"/> | Developmental Delay - only valid for a child aged 0-5 years | <input type="checkbox"/> |

**(a) Please also write your disability's specific name type and degree in the space provided below:- (Not Medical Condition/s)**

Primary Disability: **A.**

Other Disabilities: **B.**

\* The impact and persistence of ADD/ADHD is highly variable across individuals. As such, there is not sufficient evidence to conclude that under the Queensland Disability Services Act 2006, people with ADD/ADHD could be recognised as having a disability. People who have ADD/ADHD and a coexisting disability may receive services from Department of Communities Disability Services direct or funded services.

10. 1). Does this person use a wheelchair? **Yes**  **No**
- 2). Does this person use a hoist? **Yes**  **No**
- 3). Does this person use a Communication Board? **Yes**  **No**
- 4). Does this person use crutches? **Yes**  **No**
- 5). Does this person use a walking stick or frame? **Yes**  **No**
- 6). Does this person use a wheelie walker? **Yes**  **No**

**10.(a) What are this person's :**

Strengths \_\_\_\_\_

Weakness \_\_\_\_\_

**10.(b) How would you describe this person's level of interest in recreation/leisure?**

- Low  Average  High

**11. How often does the service user need personal help or supervision with activities or participation in the following life areas?**

Please indicate the level of help or supervision required for each life area (rows a-i) by ticking only one level of help or supervision (columns 1-5)

The person can undertake activities or participate in this life area with this level of personal help or supervision (or would require this level of help or supervision if the person currently helping were not available)	1) Unable to do or always needs help / supervision in this life area	2) Sometimes needs help / supervision in this life area.	3) Does not need help/ supervision in this life area but uses aids or equipment.	4) Does not need help / supervision in this life area and does not use aids or equipment	5) Not applicable
<b>LIFE AREA</b>					
<b>A. Self – Care</b> e.g. washing oneself, dressing, eating, toileting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B. Mobility</b> e.g. moving around the home and/or moving around away from home (incl. using public transport or driving a motor vehicle ), getting in or out of bed or a chair.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C. Communication</b> e.g. making self understood, in own native language or preferred method of communication if applicable, and understanding others communication and to understand people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>D. Interpersonal interactions and relationships</b> e.g. actions and behaviours that an individual does to make and keep friends and relationships, behaving within accepted limits, coping with feelings and emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NOTE: In the following questions 'not applicable' is a valid response ONLY IF the person is 0-4 years old</b>					
<b>E. Learning, applying knowledge and general tasks and demands</b> e.g. understanding new ideas, remembering problem solving, decision making, paying attention, undertaking single or multiple tasks, carrying out daily routine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Education</b> e.g. the actions, behaviours and tasks an individual performs at school, college, or any educational setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Community (civic) and economic life</b> e.g. recreation and leisure, religion and spirituality, human rights, political life and citizenship, economic life such as handling money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NOTE: In the following questions 'not applicable' is a valid response ONLY IF the person is 0-14 years old</b>					
<b>H. Domestic life</b> e.g organising meals, cleaning, disposing of garbage, housekeeping, shopping, cooking, home maintenance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Working</b> e.g. actions, behaviours and tasks to obtain and retain paid employment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Mother Craft</b> (Post Natal) e.g. organisational, ability and aptitude with new baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. Parenting Skills</b> e.g. bringing up children and young adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. Other Day Activity</b> e.g. leisure, recreation and alternatives to paid support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## 12. Carer arrangements (informal)

The following questions are asking about the presence of an **informal carer** who provides support to the service user (i.e. these questions are **not about paid support workers**)

**12a.** Does the service user have an **informal carer**, such as a family member, friend or neighbour, **who provides care and assistance** on a regular and sustained basis?

Yes  Go to 12b      No  Go to 13

'Regular' and 'sustained' in this instance means that care or assistance has been ongoing, or likely to be ongoing for at least six months.

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**12b.** Does the carer assist the service user in the area(s) of **self-care, mobility or communication**?

Yes       No

Questions 12b-e relate the informal carer identified in 12a

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**12c.** Does the carer live in the **same household** as the service user?

Yes, Co-resident carer       No, Non-resident carer

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**12d.** What is the **relationship** of the carer to the service user?

Wife/female partner	<input type="checkbox"/>	Brother	<input type="checkbox"/>
Husband/male partner	<input type="checkbox"/>	Daughter-in-law	<input type="checkbox"/>
Mother	<input type="checkbox"/>	Son-in-law	<input type="checkbox"/>
Father	<input type="checkbox"/>	Other female relative	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	Other male relative	<input type="checkbox"/>
Son	<input type="checkbox"/>	Friend/neighbour - female	<input type="checkbox"/>
Sister	<input type="checkbox"/>	Friend/neighbour - male	<input type="checkbox"/>

When answering this question complete the sentence **The carer is the service user's**

This question relates to the informal carer identified in 12a

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**12e.** What is the **age group** of the carer?

Less than 15 years	<input type="checkbox"/>	45 - 64 years	<input type="checkbox"/>
15 - 24 years	<input type="checkbox"/>	65 years and over	<input type="checkbox"/>
25 - 44 years	<input type="checkbox"/>		

When asking the service user about the age of their carer it is considered more appropriate to ask about broad age groups rather than actual age

*Only complete question 13 if the service user is aged under 16 years*

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13. **If under 16 years :** do the service user's parents or guardians receive the **Carer Allowance (Child)**?

Yes  No  Not Known

This question is not asking about Carer Payment even though some parents of children aged less than 16 years receive it in addition to Carer Allowance (Child)

*Only complete question 14 if the service user is aged 15 years or more*

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14. **If aged 15 years or more:**  
What is the service user's main source of income?

Employed  Unemployed  Not in the labour force

*Only complete question 15 if the service user is aged 16 years or more*

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- 15.. **If aged 16 years or more:**  
What is the service user's main source of income?

Disability Support Pension  Other income   
Other Pension / Benefit  Nil income   
Paid Employment  Not known   
Compensation Payments

*Continue questions for service users of all ages*

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16. Is the service user currently receiving **individualised funding** from Department of Communities Disability Services?

Yes  No  Not Known

17. Does this person have a **Community Case Manager** from:

A). Family Services / Child Safety? Yes  No  Name: \_\_\_\_\_  
B). Mental Health Services? Yes  No  Name: \_\_\_\_\_  
C). Community Health? Yes  No  Name: \_\_\_\_\_  
D). Disability Services Queensland? Yes  No  Name: \_\_\_\_\_  
E). Public Trustee? Yes  No  Name: \_\_\_\_\_  
F). Other? Yes  No  Name: \_\_\_\_\_

18. A. Does this person have any **allergies**?

Yes  No

If **YES**, what are they? \_\_\_\_\_  
\_\_\_\_\_

B. Does this person have **seizures / convulsions**?    Yes     No

C. Is this person a **diabetic**?    Yes     No

If **YES**, how is this managed? \_\_\_\_\_

D. Is this person on **medication**?    Yes     No

If **YES**, please identify type & dosage?    **Type:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

E. Does the person need **medication prompts**?    Yes     No

If yes, medication prompts can only be actioned if medication is within a Webster Pack..

Are there any special issues to be known around a **medical condition** so as to be responsive but not responsible?

Yes     No

If yes, please write what:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does the person have any known rituals?    Yes     No

If yes, what are they?

\_\_\_\_\_  
\_\_\_\_\_

G. Does the person have any behaviour challenges?    Yes     No

If yes, what are they and what are the triggers?

\_\_\_\_\_  
\_\_\_\_\_

H. Does the person have Restrictive Practise Issues?    Yes     No

Authorised by the Adult Guardian through the Guardianship Administration Tribunal?

If yes, what type?

Chemical Restraint?    Yes     No

Physical Restraint?    Yes     No



# ATTENTION

## THIS PAGE TO BE COMPLETED BY THE CHIEF EXECUTIVE OFFICER OF “QUEENSLAND LIFESTYLE SERVICES INC.” ONLY

<b>Reason for Intervention</b>	TRS <input type="checkbox"/>	Mobile Service <input type="checkbox"/>	RSP <input type="checkbox"/>
Stress	<input type="checkbox"/>	Family Breakdown	<input type="checkbox"/>
Risk of Judicial Prejudice	<input type="checkbox"/>	Community Agency Support	<input type="checkbox"/>
Inappropriate Institutionalisation	<input type="checkbox"/>	Insufficient Funds	<input type="checkbox"/>
Other _____	<input type="checkbox"/>		

TRS Hours ( ) allocated to: \_\_\_\_\_ at \$30.00 per hour.

TRS Brokeraged Agency providing support: \_\_\_\_\_

Total amount of Funds provided incl. GST to TRS Brokeraged Agency \$ \_\_\_\_\_

Was the TRS Critical Need/s Met      Yes       No

Was the Mobile referral successful?      Yes       No

Was the RSP referral successful?      Yes       No

### Service Intervention Outcome

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