

Relevant CONSENT to provide this information (E.g. Recipient / next of kin / power of attorney)	
Name	
Relationship	

ELIGIBILITY: Please indicate recipients aged care service	
Living in Residential Aged Care	<input type="checkbox"/>
Receiving or waitlisted for a Home Care Package	<input type="checkbox"/>

REFERRER		PROVIDER – Aged Care or Home Care	
Name		Provider	
Relationship to Recipient		Contact Person/ Position	
Phone number		Address inc postcode	
Email		Phone	
Organisation (if relevant)		Email	

RECIPIENT'S DETAILS	
First Name	
Preferred Name	
Title & Surname	
Gender	
Pronouns	
Date of Birth	
Country of Origin	
Preferred Language/s	

SPECIAL NEEDS Does the Recipient identify as any of the following (indicate at least one)	
<input type="checkbox"/> Culturally and Linguistically Diverse	<input type="checkbox"/> Financially or socially disadvantaged
<input type="checkbox"/> Cognitive Impairment / Dementia	<input type="checkbox"/> Aboriginal or Torres Strait Island Community
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Mental Health / Significant Trauma
<input type="checkbox"/> Vision Impairment/Low Vision	<input type="checkbox"/> LGBTIQA+
<input type="checkbox"/> Homeless or at risk	<input type="checkbox"/> Veterans
<input type="checkbox"/> Rural or remote	<input type="checkbox"/> Disability
<input type="checkbox"/> Care-leavers (e.g Forgotten Australians, Former Child Migrants, Stolen Generations)	<input type="checkbox"/> Parents separated from children - forced adoption or removal

HEALTH STATUS Please include as much detail as possible against relevant status This information is vital to ensure a suitable match			
Mobility		Hearing	
Vision		Speech	
Mental Health		Challenging behaviour	
Dementia		Other (that may impact visits)	

ABOUT THE RECIPIENT	
Reason for referral	
Background eg. Work, Family, Culture	
Hobbies and Interests	
Current visitors and relationships	
Suggested activities for visitor	
Ability to go on outings without personal care support? (Eg: Recipient must be able to handle their own money, alight in/out of car and use bathroom independently)	

VISITOR PREFERENCES – who would the recipient like to match with?					
Gender		Age range		Does the visitor need to be COVID vaccinated?	
Language or Cultural Preferences				Religion (if relevant)	
Other (please include any preferences that will help make a suitable match)					
During lock downs (e.g. COVID 19, Gastro) we offer virtual visits. Which are suitable?			<input type="checkbox"/> Phone	<input type="checkbox"/> Video e.g. Skype	<input type="checkbox"/> Letters / Emails

Home Care Package recipients ONLY			
Home Address			Phone
Emergency contact		Relationship	
Contact Phone (1)		Home Visit Safety Checklist Supplied?	

**Agreement:**

<input type="checkbox"/> The ACVVS program has been explained to the recipient. <input type="checkbox"/> I have received the relevant consent to share this information. <input type="checkbox"/> I consent to this form being shared with the ACVVS State Network in the event a suitable match can not be secured by MS Plus, in which case another ACVVS auspice may be in contact to arrange a volunteer.	Referrer Name	
	Signature	
	Date	

Any questions please contact: [ACVVSadmin@msplus.org.au](mailto:ACVVSadmin@msplus.org.au) or 03 9845 2729