



THE MOORING

SOCIAL WORKERS' REFERRAL FORM 2025

- Request for The Mooring support with accommodation and / or wrap around care.
- Please phone The Mooring 0401766042 to discuss the referral prior to emailing the form if possible.
- The Mooring also provides wrap around care for families in Hospital Foundation funded accommodation.

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| Referral has been discussed and consented to pass on the following details: Yes <input type="checkbox"/> No <input type="checkbox"/> (please note - referral cannot be made without consent) | |
| Referral Date: | Patient Name: |
| Contact Name: | Relationship to Patient: |
| Contact Number: | Suburb/Town of Origin: |
| Alternate Contact Number: | Eligible for: <input type="checkbox"/> IPTAAS <input type="checkbox"/> PTSS <input type="checkbox"/> Not eligible |
| Does the client have a car? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is the patient of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander | |
| Notes: Please provide brief description of circumstances and support needs: (This referral will be passed on to the carer) | |
| Accommodation preferred option: (For The Mooring support, if unsure of unit availability tick B & C) Start Date: _____ Anticipated length of stay: _____ Number of People: _____ | |
| A. <input type="checkbox"/> Hospital Foundation: Booked at: <input type="checkbox"/> Ashmore Palms <input type="checkbox"/> Southport Motel Number of nights: B. <input type="checkbox"/> The Mooring Unit: Bulk Billed <input type="checkbox"/> IPTAAS <input type="checkbox"/> PTSS or <input type="checkbox"/> Client Contribution \$ p/n C. <input type="checkbox"/> The Mooring to subsidise <input type="checkbox"/> Ashmore Palms <input type="checkbox"/> Southport Motel - Client to pay \$ p/n D. <input type="checkbox"/> Motel: Bulk Billed <input type="checkbox"/> IPTAAS <input type="checkbox"/> PTSS at <input type="checkbox"/> Ashmore Palms <input type="checkbox"/> Southport Motel Gap \$ E. <input type="checkbox"/> Accommodation not required | |
| Wrap around care needs: <input type="checkbox"/> Care Pack <input type="checkbox"/> Meals <input type="checkbox"/> Toiletries <input type="checkbox"/> Initial Transport <input type="checkbox"/> Clothes <input type="checkbox"/> Grocery Voucher <input type="checkbox"/> Taxi/ Uber Voucher <input type="checkbox"/> Petrol Voucher <input type="checkbox"/> Other: _____ | |
| Referral made by: | Signature: |
| Contact Number: | Department/Ward/Position: |
| Phone referral - Spoke to: | Referral Form emailed: <input type="checkbox"/> Yes |