**Privacy**

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information.

Without this information, the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment.

If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at www.tac.vic.gov.au

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

|  |  |  |
| --- | --- | --- |
| 1. Service Type
 | Choose an item |  |
|  |  |  |
| 1. Reason for Referral
 | Choose an itemSpecify if needed or delete |  |
|  |  |  |
| 1. Consent
 |  |  |
|  |  |  |
| Has the client provided verbal consent to this referral? | [ ]  Yes | [ ]  No |
|  |  |  |
| Has the client provided written consent to this referral? | [ ]  Yes | [ ]  No |

|  |
| --- |
| 1. Client Details
 |
| Client name  |  | Claim number |
|  |  |  |
|  |  |  |
| Client address |  | Client telephone number |
|  |  |  |
|  |  |
|  |  | Client Email |
| Postcode |  |  |  |
|  |  |  |  |
| Date of accident |  | Date of birth |
| Choose date |  | Choose date |
|  |  |  |
| Country of birth |  | Language Spoken |
|  |  |  |
|  |  |  |
| Does the person identify as Aboriginal or Torres Strait Islander? | [ ]  Yes | [ ]  No |
|  |  |  |
| Is the person from the CALD community? | [ ]  Yes | [ ]  No |
|  |  |  |
| Interpreter required? | [ ]  Yes | [ ]  No |

|  |
| --- |
| 1. Service Provider Details
 |
| Provider name  |  | Telephone number |
| Please select |  |  |
|  |  |  |
| Date of referral |  | Fax/email |
| Choose date |  |  |
|  |  |  |
| 1. Referring TAC Coordinator
 |
| Name |  | Telephone |
|  |  |  |
|  |  |  |
| Email |  | Fax |
| @tac.vic.gov.au |  |  |

1. Current Treatment/Services

|  |  |  |
| --- | --- | --- |
| Service Type | Provider Details | Has the client consented to this provider being contacted? |
|  |  | [ ]  Yes | [ ]  No |
|  |  | [ ]  Yes | [ ]  No |
|  |  | [ ]  Yes | [ ]  No |
|  |  | [ ]  Yes | [ ]  No |
|  |  | [ ]  Yes | [ ]  No |

1. List any known risks with visiting the client in their home/community or other relevant information

|  |
| --- |
| Please consider the following: Substance misuse; History of violence; History of self-harm; Known criminal history; Issues with home environment; Any other information that will support improved safety/risk management |

|  |
| --- |
| 1. Support Needs
 |
| Accident injuries |
|  |
|  |
| Pre-existing conditions |
|  |
|  |
| Current treatment |
|  |
|  |
| Current medications |
|  |
|  |
| Current employment & education status (type / duration / level achieved) |
|  |
|  |
| Current accommodation and living situation (type / duration / living with) |
|  |
|  |
| Psychosocial history and supports (family / marital status / relationships & supports where relevant) |
|  |
|  |
| Other, e.g. life support and medical/safety monitoring equipment, non-transport-related barriers, areas of support, barriers, failed interventions, etc. |
|  |

|  |
| --- |
| 1. Additional information
 |
| Medical/Treatment reports attached? | [ ]  Yes | [ ]  No |
|  |
| If yes, please list reports |
|  |
|  |
| Other comments |
|  |

FOR SERVICE PROVIDER COMPLETION

1. Outreach/CM Service Referral Outcome

**Please sign the referral outcome below and send to the TAC within 48 hours of receipt of original referral.**

|  |  |  |
| --- | --- | --- |
| Do you accept the referral for Outreach/CM Services? | [ ]  Yes | [ ]  No |

**If the referral is accepted:**

* Contact the TAC Coordinator to progress client engagement/needs assessment.
* Contact the client within a 2 week period or if the referral is for crisis management, as soon as possible.

**If the referral is not accepted:**

* Contact the TAC Coordinator to discuss rationale and any recommendations
* Indicate reason for non-acceptance below:

|  |
| --- |
| Choose a reason |

|  |  |
| --- | --- |
| Signature of service provider worker if referral is accepted |  |
|  |  |
|  |  |
| Print name |  |
|  |  |
|  |  |
| Date |  |
| Choose date |  |