Carer Gateway
An Australian Government Initiative | wellways

Carer Gateway
Service Area NSW 2 Referral Form

Please forward your referral to: **communityengagementnsw2@wellways.org**

Carer Information

First name: _____ Surname: _____

Address: _____

Postcode: _____ Phone number: _____

Email: _____ DOB: ____/____/____

Gender: _____ Accommodation Setting: _____

Aboriginal or Torres Strait Islander:

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both

Other cultural background: _____

Language spoken at home: _____ Country of birth: _____

Interpreter required: ☐ Yes ☐ No Do you identify as LGBTQIA+: ☐ Yes ☐ No

Additional support required E.g. Speech or hearing services: _____

Care Recipient Information

Name: _____ DOB: ____/____/____

Diagnosis: _____

_____

_____

Relationship to Care Recipient: _____

Emergency Contact

Name: _____ Relationship to Carer: _____

Phone number: _____

Is the Participant aware of this referral? ☐ Yes ☐ No

Participant's signature: _____ Date: ____/____/____

Parent/Guardian (If under 18): _____ Date: ____/____/____

☐ Verbal consent given for follow up