

**Fairfield Food Services Inc.
Service Delivery Assessment**

REFERRAL DETAILS

Date of Referral		Client Aware of Referral?	
Referred By			
Phone		Mobile	
Referral Taken by?			
If Client registered with MY AGED CARE? If Yes, provide referral code for meals.			

CLIENT DETAILS

Clients Name			
Address			
Phone		D.O.B.	
Country of Birth		Language Spoken at Home	
Does the client wish to nominate an Advocate? If so name and contact details			

EMERGENCY CONTACT DETAILS

First Contact :		Relationship	
Address:			
Day Time Ph.		Mobile Ph.	
Second Contact :		Relationship	
Address:			
Day Time Ph.		Mobile Ph.	

MEAL INFORMATION

Dislikes
Special Dietary Requirements

IF CLIENT NOT HOME

If not home to a scheduled visit, we will not leave the meal.
 Are you willing for our staff to:
 Telephone Client Telephone NOK/rep Local Hospitals(if NOK not contactable)

If there is concern that the client may be injured or ill inside the house or unable to contact the NOK/rep, are you willing for the Executive Officer/delegated staff member to contact:

Ambulance Police

SAFETY

Are there safety issues regarding delivery? (dog, hazardous steps etc) What arrangements have been made with the client to minimise risk to volunteers?

BILLING INFORMATION

Bill to:			
Address			
Number of Meals Delivered each Week?		Cost per week \$	

CLIENT CONSENT

I (name of Client).....
have been provided with information and have had the opportunity to ask questions and after due consideration I give my consent to:

Authority to Enter Premises: I hereby give permission:
 1. for staff and volunteers of the Fairfield Food Services to enter my premises in order to deliver meals as requested.
Clients Initial if consent granted.....

Payment for Meals Provided: I confirm that:
 1. that Fairfield Food Services have explained to me the charges for the meals which I am to receive and
 2. I agree to pay for those meals as detailed in this assessment
 3. I have been advised to contact the service should my ability to pay change in anyway
Clients Initial if consent granted.....

Contact with Next of Kin/Carer/Emergency Contact: I give permission:
 for the staff of Fairfield Food Services to contact my Next of Kin/ Carer/Emergency Contact under circumstances where they are concerned for my quality of life, health or safety under duty of care.
Clients Initial if consent granted.....

Consent to Access Information: I hereby give permission to Fairfield Food Services to:
 1. access my records so as to change those records as requested by me or my nominated advocate
 2. to pass on my assessment information for the purpose of referrals to other agencies after they have gained my verbal or written permission.
 3. Release non identifying information regarding my service to funding bodies as part of the services funding obligations.
Clients Initial if consent granted.....

Client Signature :

Date:

DELIVERY SCHEDULE (Office use only)

Allocated Run	Commencement Date				
	Mon	Tues	Wed	Thur	Fri
Meals					
Soups					
Desserts					