

# Consumer information

**Purpose: to collect common demographic and other essential consumer information that can be shared with another agency.**

## Consumer details

Family name: \_\_\_\_\_  
 Given names: \_\_\_\_\_  
 Preferred name/s: \_\_\_\_\_  
 Date of birth: dd/mm/yyyy \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Is the date of birth estimated? ☐ Yes ☐ No  
 Gender: \_\_\_\_\_ Title: \_\_\_\_\_  
 Home address \_\_\_\_\_  
 \_\_\_\_\_ Post code: \_\_\_\_\_  
 Postal address (if different from above): \_\_\_\_\_  
 \_\_\_\_\_ Post code: \_\_\_\_\_

## Contact phone numbers

Can leave message? ☐ Yes ☐ No  
 Home number: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_  
 (tick preferred number)  
 Home: ☐ Yes ☐ No Work: ☐ Yes ☐ No  
 Mobile: ☐ Yes ☐ No Email: ☐ Yes ☐ No  
 Are you a carer or care recipient? ☐ Yes ☐ No

## Employment/student status Code:

Comments: \_\_\_\_\_  
 Country of birth: \_\_\_\_\_  
 Indigenous status: \_\_\_\_\_  
 Are you of Aboriginal and/or a Torres Strait Islander origin?  
☐ Yes ☐ No ☐ Not stated/unknown  
 Refugee status: ☐ Yes ☐ No ☐ Not stated/unknown  
 If yes, year of arrival: \_\_\_\_\_  
 Need for interpreter services: ☐ Yes ☐ No  
 Preferred language: \_\_\_\_\_  
 Communication method: \_\_\_\_\_

## General Practitioner (GP)

GP name: \_\_\_\_\_  
 Practice name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 email: \_\_\_\_\_

## Who the agency can contact if necessary

(for example. carer, parent, next of kin, guardian, friend, emergency contact, case manager, support worker)

### Contact 1 Name:

Home address \_\_\_\_\_  
 \_\_\_\_\_ Post code: \_\_\_\_\_  
 Phone numbers  
 Home: \_\_\_\_\_  
 Work: \_\_\_\_\_  
 Mobile: \_\_\_\_\_  
 Relationship to consumer: \_\_\_\_\_

### Contact 2 Name:

Home address \_\_\_\_\_  
 \_\_\_\_\_ Post code: \_\_\_\_\_  
 Phone numbers  
 Home: \_\_\_\_\_  
 Work: \_\_\_\_\_  
 Mobile: \_\_\_\_\_  
 Relationship to Consumer: \_\_\_\_\_

## Government pension/benefit status:

If on a disability support pension nature of disability: \_\_\_\_\_

## Health care card holder status:

Card number: \_\_\_\_\_ Expiry: \_\_\_\_\_

## Medicare card & status:

Card number: \_\_\_\_\_ Expiry: \_\_\_\_\_

## Health insurance status:

Insurer name: \_\_\_\_\_  
 IRN number: \_\_\_\_\_  
 Card number: \_\_\_\_\_ Expiry: \_\_\_\_\_

## DVA card entitlement:

DVA card type: \_\_\_\_\_  
 DVA card number: \_\_\_\_\_ Expiry: \_\_\_\_\_

## Compensable funding source:

Comments