



Phone: 1300 599 532
Fax: 02 9870 8640
Email: carecall@theinsgroup.com.au

CARECALL REFERRAL

Please complete the following and return to INS CareCall via fax or email as soon as possible.

Date of Referral: _____ Name of Referrer: _____

Organisation: _____

Business number: _____ Fax: _____

Referrer Type: Doctor OT Discharge Planner Community Organisation

NDIS – NDIS Reference # _____

Client's date of birth: _____

Has client consented to discuss their plan? Yes / No

OTHER _____

Is client aware of referral? Yes / No

Is system funded by your organisation? Yes / No

Extras? Add'l Transmitter Smoke Detector Security Key Holder Fall Sensor

Personal Details:

Title: _____ Surname/s: _____

Given Name/s: _____

Address Details:

Type of Dwelling: House Flat Unit Villa Other: _____

Home Ph No: _____ Mobile Ph No: _____

Property Name: _____

Street Address: _____

Suburb / Town: _____ State: _____ P/Code: _____

Nearest Cross St: _____

Person to be contacted re-installation or other enquires:

Surname: _____ Relationship: _____

Title: _____ Given Name/s: _____

Street Address: _____

Suburb / Town: _____ State: _____ P/Code: _____

Home No: _____ Mobile No: _____

Does this person wish to be present at time of installation? Yes / No

THIS FACSIMILE IS PRIVATE AND CONFIDENTIAL. IF RECEIVED IN ERROR, PLEASE CONTACT INS CARECALL ON 1300 599 532 AND DESTROY THE TRANSMISSION.