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| **REFERRAL FORM - NDIS** |

**PARTICIPANT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Participant Number\*** | | Click to enter text. | | |
| **NDIS Plan Dates\*** | **Start:** | Click or tap to enter a date. | **Finish:** | Click or tap to enter a date. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Title** | Choose an item. | | **Date of Birth\*** | | Click or tap to enter a date. | |
| **Given Name/s\*** | Click to enter text. | | **Last Name\*** | | Click to enter text. | |
| **Contact Number\*** | Click to enter text. | | **Mobile** | | Click to enter text. | |
| **Address\*** | Click to enter text. | | | | | |
| **Suburb\*** | Click to enter text. | | | | | |
| **State/Post Code** | Click to enter text. | | | | | |
| **Email** | Click to enter text. | | | | | |
| **Preferred Method of Contact\*** | | Phone | | Email | | Post |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Translator Required?\*** | | YES  NO | | **Language** | Click to enter text. |
| **Other communication requirements:** | | | Click to enter text. | | |
| **NDIS approved diagnoses \*** | Click to enter text. | | | | |

**LEGAL REPRESENTATIVE DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Given Name** | Click to enter text. | | **Last Name** | | Click to enter text. | |
| **Contact Number** | Click to enter text. | | **Mobile** | | Click to enter text. | |
| **Email** | Click to enter text. | | | | | |
| **Relationship to Participant** | | Choose an item. | | **Other Details** | | Click to enter text. |

**REFERRED SERVICE FUNDING ARRANGEMENTS\***

|  |  |
| --- | --- |
| Self-Managed Funding | |
| Funding Managed by National Disability Insurance Agency | |
| Funding Managed by Register Plan Management Provider | |
| **Provider Name** | Click to enter text. |
| **Contact Person** | Click to enter text. |
| **Contact Number** | Click to enter text. |
| **Email** | Click to enter text. |

\*required field

**REFERRAL REQUEST**

|  |  |
| --- | --- |
| **FUNDED SUPPORT** | **REFERRAL TYPE** |
|  | Queensland and South Australia: |
| Coordination of Supports (SC & SSC)  **Funds available:** Click to enter text. | Coordination of Supports (SC) – Level 2  Specialist Support Coordination (SSC) – Level 3 |
| Improved Daily Living (OT, EP, DE)  **Funds available:** Click to enter text. | South Australia only:  Occupational Therapy (OT) |
| Improved Health/Wellbeing (EP)  **Funds available:** Click to enter text. | Exercise Physiology (EP)  Specialist Behaviour Intervention (PBS) |
| Improved Relationships (PBS)  **Funds available:** Click to enter text. | Behaviour Management Plan (PBS)  Developmental Education (DE) |

**REFERRAL DETAILS**

|  |
| --- |
| Click to enter text. |

**DESIRED REFERRAL OUTCOME (ALLIED HEALTH)**

Functional Capacity Assessment  Exercise plan and treatment

Positive Behaviour Supports  Assistive technology assessment & report

Treatment/Therapy Support  Home modification assessment & report

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| --- |
| **Other:** Click to enter text. |

**OTHER HEALTH ISSUES**

|  |  |
| --- | --- |
| **Additional disabilities and health concerns\*** | Click to enter text. |

**ADDITIONAL INFORMATION**

|  |
| --- |
| Click to enter text. |

**POSITIVE BEHAVIOUR SUPPORT**

Is there a Positive Behaviour Support Plan in place?\*

Yes  No

**BEHAVIOUR SUPPORT REFERRAL ONLY**

|  |  |
| --- | --- |
| **Primary behaviours of concern** | Click to enter text. |
| **Restrictive practices in place** | Click to enter text. |
| **Details current behaviour support plan** | Click to enter text. |

**FORM COMPLETED BY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click to enter text. | **Date** | Click or tap to enter a date. |
| **Organisation** | Click to enter text. | **Position** | Click to enter text. |

**Please email completed form to referrals@communityassist.com.au**