|  |
| --- |
| **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

|  |
| --- |
| **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**