**REFERRAL FORM** **FOR NDIS PARTICIPANTS**

1. **NDIS PARTICIPANT DETAILS**

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| --- | --- |
| First Name: | Last Name: |
| Date of Birth:  | Phone:       |
| Gender:      [ ]  Male [ ]  Female [ ]  Prefer not to say | Email:       |
| Address: Suburb:       State: **QLD**  Postcode:       |
| Alternative Contact: (*in case the NDIS participant or Support Coordinator is unreachable*)Name:       Phone:      Relationship:       Email:       |
| NDIS Plan Number:  | NDIS Plan Dates:       to       Start Date End Date |
| Living Arrangement: [ ]  Alone [ ]  Family/Partner [ ]  Supported Accommodation [ ]  Other |
| Preferred Language:A translator/interpreter or communication aids required?Details:      |

1. **REFERRER DETAILS**

[ ]  Check this box if you are referring yourself and move to **section 3**

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| Name of Organisation: (if applicable)  |
| First Name | Last Name:  |
| Phone: | Postcode:       |
| Email:  |
| Job Title / Role: [ ]  Support Coordinator [x]  NDIS Planner [ ]  Local Area Coordinator [ ]  Family memberOther:       |

1. **BACKGROUND (INFORMATION ABOUT PRIMARY / KEY DISABILITIES)**

*Participants Background (a little bit of information about you /client and your/their Key Disability/s listed with the NDIS.*

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| **Please advise:**       |

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| **What would you/ your client like to achieve from this referral?**       |

1. **WHAT BEST DESCRIBES THE REASON FOR THE REFERRAL?**

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| [ ]  Functional Capcity Assessment and Report for NDIS Planning and Funding:  |
| [ ]  Assistive Technology (equipment) |
| [ ]  Home Modifications |

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| Please advise if any other Allied Health Professionals have prescribed you/ your client any Assistive Technology, Home Modifications or written any reports.(Provide details if applicable):      |

1. **PLEASE ADVISE YOUR NDIS PLAN GOALS**

*(Your welcome to email through the relevant pages of your NDIS Plan with goals listed if easier)*

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| Please advise goals as stated in your NDIS Plan:       |

1. **SAFETY**

*(In order to proceed with your referral ALL questions* ***MUST*** *be ticked.****)***

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| --- | --- |
| Is anyone at your / the client’s property, known to be aggressive or violent?If Y – please advise: | [ ]  Y [ ]  N |
| Does anyone at your/the clients property have a criminal history?If Y – please advise: | [ ]  Y [ ]  N |
| Does the client have a positive behavioural support plan in place?If Y – please attach a copy of PBS | [ ]  Y [ ]  N |
| Is there a history of drugs or alcohol misuse at the property?If Y – please advise: | [ ]  Y [ ]  N |
| Are you aware of any firearms being stored at the property?If Y – please advise: | [ ]  Y [ ]  N |
| Are you aware of any occupant having an infectious disease? (i.e. chicken pox / shingles / gastro, etc.)If Y – please advise: | [ ]  Y [ ]  N |
| Do you have any pets at your premises? ­­­ | [ ]  Y [ ]  N |
| Are there any other factors we should be aware of? If YES, please describe:  | [ ]  Y [ ]  N |

1. **PAYMENT OF ACCOUNT / INVOICES**

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| Who is responsible for paying the account / invoice? (please select one)[ ]  Plan Managed - Organisation Name: [ ]  Self-Managed**If you selected Plan Manager or Self-Managed, please complete the following details:**Name of person responsible for the account:       Phone:      Email:        |

1. **TO COMPLETE THIS REFERRAL FORM**

Please state your full name and date this referral and return via email the completed form to:

**Email:** **RAHS@outlook.com.au**

**Full Name:**

**Date:**

Following receipt of your referral we will confirm we can schedule in an appointment for you to see our Occupational Therapist and forward a Service Agreement for your review.