**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**

|  |  |
| --- | --- |
| Name of Organisation: (if applicable) | |
| First Name | Last Name: |
| Phone: | Postcode: |
| Email: | |
| Job Title / Role:  Support Coordinator  NDIS Planner  Local Area Coordinator  Family member  Other: | |

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**](mailto: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.