RAHS REFERRAL FORM FOR NDIS PARTICIPANTS

1. NDIS PARTICIPANT DETAILS

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:	

2. 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:	

3. 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.

Please advise:

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

4. WHAT BEST DESCRIBES THE REASON FOR THE REFERRAL?

☐ Functional Capacity Assessment and Report for NDIS Planning and Funding:
☐ Assistive Technology (equipment)
☐ Home Modifications

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):

5. PLEASE ADVISE YOUR NDIS PLAN GOALS

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

Please advise goals as stated in your NDIS Plan:

6. SAFETY

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

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

7. PAYMENT OF ACCOUNT / INVOICES

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:

8. 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.