CARE PLUS SUPPORT SERVICES

CLIENT RFERRAL FORM

Participant Details

FULL NAME

DATE OF BIRTH (DD/MM/YYYY)

GENDER

MALE FEMALE OTHER

PARTICIPANT NDIS NUMBER

ADDRESS

PHONE

MOBILE

EMAIL

ALTERNATIVE CONTACT PERSON

FULL NAME

CONTACT NUMBER

EMERGENCY CONTACT – PERSON 1

FULL NAME

CONTACT NUMBER

EMERGENCY CONTACT – PERSON 2

FULL NAME

CONTACT NUMBER

CURRENT LIVING ARRANGEMENTS (WITH FAMILY, ALONE, OR SHARING WITH OTHERS)

CULTURAL BACKGROUND

- TORRES STRAIT ISLANDER
- ABORIGINAL
- ABORIGINAL & TORRES STRAIT ISLANDER
- NONE OF THE ABOVE
- CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) (PLEASE SPECIFY BELOW)

REFERRAL FORM

SOURCE OF REFERRAL

SELF FAMILY AGENCY NDIA LAC

OTHER E.G SUPPORT COORDINATOR (PLEASE SPECIFY)

OTHER E.G SUPPORT COORDINATOR (PLEASE SPECIFY)

NEXT OF KIN / SIGNIFICANT OTHER PERSON

FULL NAME

RELATIONSHIP

ADDRESS

PHONE

EMAIL

DIAGNOSIS

Please Provide Details if Applicable

Primary Diagnosis

Secondary Diagnosis

Assistance required with medication?

Does the individual have Epilepsy, Seizures, Asthma, Allergies?

Assistance required with mobility e.g., wheelchair, walker, hoists?

Any other safety concerns, or Behaviours of concerns etc ?

HOW DID YOU HEAR ABOUT US?

REFERRAL FORM

REASONS FOR THIS REFERRAL

Details if Applicable, Or Hours/Week

- ○ SOCIAL AND COMMUNITY PARTICIPATIONS
- ○ DAILY TASKS / DOMESTIC / PERSONAL CARE SUPPORTS
- ○ SHORT TERM ACCOMMODATION
- ○ CB-INCREASED SOCIAL AND COMMUNITY PARTICIPATION
- ○ SUPPORTED ACCOMMODATION / ILO / SIL SUPPORTS

THERAPY SUPPORT SERVICES

- ○ OCCUPATIONAL THERAPIST
- ○ COMMUNITY REGISTERED NURSE
- ○ COUNSELLOR OR PSYCHOLOGIST
- ○ PLAN MANAGEMENT
- ○ PLAN MANAGEMENT

HOURS/BUDGET - IF YOU KNOW

NDIS

- ○ AGENCY MANAGED
- ○ PLAN MANAGED
- ○ SELF- MANAGED

WHO MANAGES YOUR NDIS FUNDING?

If Plan Managed, provide Plan Manager contact details

FULL NAME

PHONE

EMAIL

NDIS NUMBER

NDIS PLAN START DATE

NDIS PLAN END DATE