DISABILITY SERVICES-REFERRAL FORM

Referrer Details:

Name:	**Phone / Mobile:**
Relationship To Client:	
Email:	

Participant Details:

First name:	**Surname:**
Preferred name:	**Date Of Birth:**
Address:	**Email:**

Living Arrangements:

○ **I Live Alone**	○ **I Live With Family / Housemate**	○ **Supported Accommodation**

Phone / Mobile:			
Gender:		**Pronoun:**	
Allergies:			
Primary Diagnosis:			
Secondary diagnosis:			
Religion / Cultural Identity:			
Client's Preferred Method Of Contact	**Choose an Item**	**Whom To Contact**	

Preferred Communication Needs:

- O **Verbal**
- O **Non-Verbal**
- O **Communication Device**
- O **Interpreter Required**
- O **Other**

Participant Support Requirements:

What services is the Participant Requesting	O **Social and Community participation** O **Assistance with Daily Life** • **Assistance With Medication management** • **Assistance With Self Care Activities** • **Personal Domestic Assistance** O **Increased Social & Community participation** O **Supported Accommodation – Supported Independent Living** O **Psychosocial and Transitional Accommodation**

	O **Public Holiday Services** O **Other**

NDIS Plan Details / Guardianship:

Funding Source ○ **NDIS** ○ **Dept of communities** ○ **DSOA** ○ **Other**	
NDIS Plan Number:	
NDIS Plan Start date:	**Plan End Date:**
Fund management: ○ **NDIA Managed** ○ **Plan Managed** ○ **Self-Managed**	
Support Coordinator details:	
Plan Manager Details:	
Legal Guardian / Advocate Details:	
How many hours of service does the participant require?	**Hours Per Service** **Time Of The day** **Days of The week?** **Days and Times are Flexible** O **Yes** O **No**
Additional Information and Preferences for example male / female supporter worker etc	
Does the Participant have a history of behaviors of concern? O **Yes** O **No**	
Does the Participant have a history of behavior Support Plan? O **Yes** O **No** **Please Provide Copy**	
Are Restrictive practices in Place? O **Yes** O **No**	
Details of Behaviors of Concern & restrictive Practices	
Does the Participant require mobile assistance? O **Yes** O **No**	

If Yes, please detail what Mobile Assistance is required
Please Provide copy of any manual handling / transfer plans.

Does the participant have any support needs classified as High Intensity Supports (HIDPA)

- O **Yes , Please Outline**
- O **No**

Will the participant's support team require specific training?
Provide specific support / emergency response plan if available

- O **Yes, what specific training to be required?**
- O **No**

Is the participant engaged with allied health professions	O **Yes** O **No**	O **Occupational Therapist** O **Physio Therapist** O **Speech Therapist** O **Diabetes Educator** O **Mental Health Professional** O **Other**

Consents:

I understand that:

- **These records are owned by Charles Disability Services**
- **Information within these records will be shared with other staff within Charles Disability Services on and only when staff require the information to carry out their duties**
- **I can ask to see records and receive a copy**
- **Records are achieved for a set period according to policy and procedure**
- **I understand that all information will be kept confidential**

To the best of my knowledge, the information provided in this form is true and correct

Individual / Guardian Name

Signature: Date: