# **Participant Referral Form**

## 1 Participant Details

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Name |  | | | | D.O.B | | | / / | Gender | |  |
| Contact details | Home |  | Mobile | | | |  | | | | |
| Email address |  | | | | | | | | | | |
| Language spoken at home: |  | | | Interpreter required | | | | | | Yes  No | |
| Preferred option for communication | Email  Post Phone | | | | | Do you identify as Aboriginal and Torres Strait Islander?  Yes  No | | | | | |
| Residential Address: |  | | | | | | | | | | |
| Postal Address  (if different from above) |  | | | | | | | | | | |

Is there a Guardianship and/or Administration order in place?  Yes  No

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Parent/Guardian 1 |  | | | Primary Carer | | Yes | No |
| Lives w/ Participant | | Yes | No |
| Emergency Contact | | Yes | No |
| Relationship to participant | Parent  Guardian  Caregiver  Other | | | | | | |
| Residential Address: |  | | | | | | |
| Postal Address  (if different from above) |  | | | | | | |
| Contact details | Home |  | Mobile | |  | | |
| Email address |  | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Parent/Guardian 1 |  | | | Primary Carer | | Yes | No |
| Lives w/ Participant | | Yes | No |
| Emergency Contact | | Yes | No |
| Relationship to participant | Parent  Guardian  Caregiver  Other | | | | | | |
| Residential Address: |  | | | | | | |
| Postal Address  (if different from above) |  | | | | | | |
| Contact details | Home |  | Mobile | |  | | |
| Email address |  | | | | | | |

2. Disability / Medical Conditions including ALLERGIES

|  |
| --- |
|  |
|  |

3. Behaviours of concern.

|  |
| --- |
|  |
|  |

4. Level of mobility (wheelchair, accessible vehicle, car seat, other)

|  |
| --- |
|  |
|  |

5. Assistive Technology

|  |
| --- |
|  |
|  |

Services Required:

|  |  |  |
| --- | --- | --- |
| Assistance with Community Access | Assistance with Personal Care | Life Skills Development |
| Coordinator of Support | Personal Training | Work Skills Development |
| Short-Term Accommodation – STA (Respite) | House/Yard Maintenance | School Leavers Employment Supports (SLES) |
| Meal Prep. & Delivery | Home Mods Labour | Assistance with Employment Engagement |
| Other: *What service would you like to provide?* | | |

Other Service Providers currently being utilised:

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone/email |  |
| Frequency of use: |  |

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone/email |  |
| Frequency of use: |  |

## 5. Health Care Information

|  |  |  |  |
| --- | --- | --- | --- |
| Medicare Number |  | Expiry Date: |  |
| Reference Number: |  |
| Private Healthcare Provider |  | Membership Number |  |
| Reference Number |  |

|  |  |
| --- | --- |
| Doctor Name |  |
| Address |  |
| Phone Number |  |

## 6. Funding

|  |  |
| --- | --- |
| NDIS Number: |  |
| NDIS Plan Dates: |  |

Self-Managed  Plan Managed

Please provide details for invoices

|  |  |
| --- | --- |
| Name |  |
| Email |  |
| Comments |  |

## 7. Preferences

|  |  |
| --- | --- |
| Preferred name |  |
| Religious Requirements |  |
| Cultural Requirements |  |
| Communication device / other |  |
| Physical Assistance |  |
| Travel Assistance |  |
| Other Considerations |  |

## 8. Goals and Aspirations

|  |  |
| --- | --- |
| What do you want to achieve for yourself – life skills, physically, socially etc? | |
|  | |
| Immediately |  |
| In 6 months |  |
| Next year |  |

9. Please indicate support times required.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| TIME | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |
| Overnight |  |  |  |  |  |  |  |

10. Referrer Details

|  |  |
| --- | --- |
| Name |  |
| Organisation |  |
| Address |  |
| Phone/email |  |

I understand that:

* These records are owned by this organisation.
* Information within these records will be shared with other staff within the organisation 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 archived for a set period according to policy and procedure
* I understand that all information obtained will be kept confidential.

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

Signature of Participant or Parent/Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick if **VERBAL CONSENT** was instead obtained from Participant.