REFERRAL FORM

ALL INFORMATION STRICTLY CONFIDENTIAL

PARTICIPANT GENERAL DETAILS	
Given Name:	
Last Name:	
NDIS Details	NDIS Number:
	Plan Start Date:
	Plan End Date:
Gender:	☐ Male ☐ Female
Date of Birth:	
Address Details	Address:
	Post Code:
Contact Details	Home:
	Mobile:
	Email Address:
Indigenous Identity	☐ Aboriginal ☐ Torres Strait Islander
Other Details	Language Spoken:
	Religion:
	Cultural Group:

PARTICIPANT PRIMARY CONTACT – NEXT OF KIN	
Name:	
Relationship to Participant:	Parent ☐ Guardian ☐ Carer ☐ Other ☐
Address:	
Contact Details	Phone Number:
	Email Address:

PARTICIPANT NDIS SUPPORT COORDINATOR	
Name:	
Service Provider Name:	
Address:	
Contact Details	Phone Number:
	Email Address:
PARTICIPANT BENEFITS	
Please indicate if the participant is in receipt of:	
A Disability Support Pension:	☐ Yes

	☐ No Pension Type: ________________________ CRN No: ___________
Any other form of a welfare benefits:	☐ Yes ☐ No If Yes, please give details: ___________________________
Any other form of income:	☐ Yes ☐ No If Yes, please give details: ____

PARTICIPANT CRIMINAL JUSTICE SPECIFIC INFORMATION	
Is your client still in prison?	☐ Yes ☐ No
What is the nature of current offences?	
Are there any current charges, orders, pending court cases or bail conditions?	☐ Yes ☐ No If Yes, please provide details: _____________________________________
Please provide contact worker at prison and their details:	• Name _____________________________________ • Telephone Number: __________________________ • Email Address: ______________________________

PARTICIPANT ACCESS REQUIREMENTS	
Type of Living Support Request: *(Please tick the box that applies to your client)*	☐ Short-Term Accommodation (Centre-based Respite) ☐ Home-Care ☐ Drop-in Support ☐ Flexible Respite ☐ Shared Independent Living Accommodation (SIL) (Long-Term Accommodation) ☐ Supported Disability Accommodation Support (SDA) (Long-Term Accommodation) ☐ Day Program Service ☐ Transport Assistance

PARTICIPANT SUPPORT NEEDS DETAILS	
Medical Diagnosis:	☐ Yes ☐ No (If Yes, please state medical condition(s))
Types of Disability:	☐ Physical Disability ☐ Sensory Disability

<table>
<tr><td>(Please tick the box that applies to your client)</td><td colspan="4">☐ Psychiatric Disability
☐ Neurological Disability
☐ Intellectual Disability
☐ Other Types (Please specify below)
______________________________________</td></tr>
<tr><td>Level of Disability</td><td colspan="4">☐ Mild ☐ Moderate ☐ Severe</td></tr>
<tr><td rowspan="4">Communication:</td><td colspan="4">☐ With Aids and Equipment
☐ Without Aids and Equipment</td></tr>
<tr><td colspan="4">Receptive communication:</td></tr>
<tr><td colspan="4">Expressive Communication:</td></tr>
<tr><td colspan="4">Interpersonal Communication:</td></tr>
<tr><td rowspan="3">Behaviour:

(Please tick the box that applies to your client)</td><td>☐ Self-Harm</td><td>☐ Wandering</td><td>☐ Drug/Alcohol</td><td>☐ Property Damage</td></tr>
<tr><td>☐ Physical Aggression</td><td>☐ Verbal Aggression</td><td>☐ Impulse Control</td><td>☐ Sexual</td></tr>
<tr><td colspan="4">OTHERS:
____
Please specify ANY Other behaviours that require consideration</td></tr>
<tr><td rowspan="4">Mental Health Condition:

(Please tick the box that applies to your client)</td><td>☐ Depression</td><td>☐ Suicidal ideation</td><td colspan="2">☐ Panic/Anxiety</td></tr>
<tr><td>☐ Bipolar disorder (mood swings)</td><td>☐ Dementia</td><td colspan="2">☐ Attention-deficit/Hyperactivity disorder</td></tr>
<tr><td>☐ Schizophrenia</td><td>☐ Obsessive compulsive disorder</td><td colspan="2">☐ Autism</td></tr>
<tr><td>☐ Post-traumatic stress disorder</td><td colspan="3">☐ OTHERS
Please specify: ______________________________________</td></tr>
<tr><td>Interests / Likes:</td><td colspan="4"></td></tr>
<tr><td>Dislikes:</td><td colspan="4"></td></tr>
<tr><td rowspan="8">Personal & Daily Living:

(Please tick the box that applies to your client)</td><td></td><td>No Assistance Required</td><td>Requires Prompting/Supervision</td><td>Requires Active Assistance</td></tr>
<tr><td>Eating/drinking</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Mobility</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Showering/bathing</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Shaving/grooming</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Dressing/dental care</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Toileting</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Laundry</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>

	Housekeeping	☐	☐	☐
	Cooking	☐	☐	☐
	Money	☐	☐	☐
	OTHERS: ____ *Please specify*			

SUPPORTING DOCUMENTATION CHECKLIST

Please attach the following documents where applicable as part of this referral

- ☐ Clinical assessments and reports
- ☐ Behavioural assessments/plans
- ☐ Functional assessment report
- ☐ Risk assessments and profile
- ☐ Speech Pathology report
- ☐ Comprehensive Health Assessment Program (CHAP) Tool
- ☐ 6-Month snapshot of Incident reports
- ☐ Restrictive Practice Authority Form
- ☐ Nutrition & Swallowing Checklist
- ☐ Allergy Plan
- ☐ Client Medication
- ☐ Police reports
- ☐ Day Program Schedule
- ☐ Participant Routine
- ☐ Any other relevant documentation

  Please specify: ____

PRIVACY

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.

The referrer and the applicant agree that no information has been withheld; all information is accurate, correct and necessary for Hale Community Support to provide the requested services to recipient and meet its obligation to staff.

Applicant's Name: _______________________________ Signature: __________________________
Date: __________________

Referrer's Name: _______________________________ Signature: ___________________________
Date: __________________

PLEASE FORWARD THIS COMPLETED FORM AND ATTACHMENTS TO:

REFERRALS, INTAKE, INFORMATION AND ASSESSMENT (RIIA) Team

hcsintake@halesupport.org.au – PH: (02) 9625 5076 / 0434 518 734