HALE COMMUNITY SUPPORT

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 & Access (Centre-based Respite) ☐ Home-Care ☐ Drop-in Support ☐ Flexible Respite ☐ Shared Independent Living Accommodation (SIL) (Long-Term Accommodation) ☐ Transitioning placement ☐ Day Program Service ☐ Transport Assistance

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

box that applies to your client)	☐ Intellectual Disability ☐ Other Types (Please specify below) _____			
Level of Disability	☐ Mild	☐ Moderate	☐ Severe	
Communication:	☐ With Aids and Equipment ☐ Without Aids and Equipment			
	Receptive communication:			
	Expressive Communication:			
	Interpersonal Communication:			
Behaviour: *(Please tick the box that applies to your client)*	☐ Self-Harm	☐ Wandering	☐ Drug/Alcohol	☐ Property Damage
	☐ Physical Aggression	☐ Verbal Aggression	☐ Impulse Control	☐ Sexual
	OTHERS: _____ *Please specify ANY Other behaviours that require consideration*			
Mental Health Condition: *(Please tick the box that applies to your client)*	☐ Depression	☐ Suicidal ideation	☐ Panic/Anxiety	
	☐ Bipolar disorder (mood swings)	☐ Dementia	☐ Attention-deficit/Hyperactivity disorder	
	☐ Schizophrenia	☐ Obsessive compulsive disorder	☐ Autism	
	☐ Post-traumatic stress disorder	☐ OTHERS *Please specify:* _____		
Interests / Likes:				
Dislikes:				

Personal & Daily Living: *(Please tick the box that applies to your client)*		No Assistance Required	Requires Prompting/Supervision	Requires Active Assistance
	Eating/drinking	☐	☐	☐
	Mobility	☐	☐	☐
	Showering/bathing	☐	☐	☐
	Shaving/grooming	☐	☐	☐
	Dressing/dental care	☐	☐	☐
	Toileting	☐	☐	☐
	Laundry	☐	☐	☐
	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 / 0435 353 292