ATLAS Disability Support

REFERRAL FROM

Participant Information

Participant Full Name

Gender Date of Birth: NDIS No

NDIS Plan Start Date: NDIS Plan End Date:

Plan Management Type: ☐ NDIA Managed ☐ Plan Managed ☐ Self-Managed

Plan Manager Name (if applicable):

Plan Manager Email:

Diagnosis:

Cultural Background/Language

Interpreter Required: ☐ Yes ☐ No

Address:

Phone:

Referrer Details

Referrer Name:

Organisation / Relationship to Participant:

Contact Number: Email:

Participant's Representative (if applicable)

Name:

Relationship to Participant: Contact Number:

Email:

Services Requested

Please tick the services the participant is being referred for:

Core Supports

☐ Assistance with Daily Living
☐ Assistance with Personal Care
☐ Assistance with Household Tasks
☐ Assistance with Community Participation

☐ In-Home Respite / Short Term Accommodation (STA)
☐ Supported Independent Living (SIL)
☐ Social & Recreational Support

Capacity Building Supports

☐ Occupational Therapy (OT)
☐ Functional Capacity Assessment (FCA)
☐ Physiotherapy
☐ Speech Pathology
☐ Psychology / Counselling
☐ Skills Development & Training (Daily Living Skills)
☐ Employment-Related Support
☐ Support Coordination
☐ Specialist Support Coordination
☐ Paediatric OT ☐ Paediatric Physiotherapy

Participant's Goals (if known)

(Please include short-term and long-term goals or NDIS plan goals if available)

Additional Information

(Any relevant background, safety concerns, risk alerts, communication needs, or behavioural considerations)

Preferred Service Location

☐ Participant's Home
☐ Community / Day Program
☐ School / Workplace
☐ Telehealth
☐ Other:

Supporting Documents (if applicable)

☐ NDIS Plan
☐ Previous Assessments / Reports
☐ Behaviour Support Plan
☐ Medical / Allied Health Reports
☐ Risk / Incident Notes

(Please attach any relevant files when submitting this form.)

Consent to Share Information

I, _____ (participant / representative name), consent to the collection and sharing of personal and health information with Atlas Disability Support for the purpose of service provision and coordination.

Date: _____

Please email the completed referral form to info@atlasdisability.com.au