
# REFERRAL FORM

All Frangipani Care Services

## Participant Details

**Full Name:** | **Preferred Name:**

**Date of Birth:** | **NDIS Number:**

**Phone:** | **Email:**

**Address:** | **Suburb/Postcode:**

**Plan Start:** | **Plan End:**

## Parent / Carer / Nominee Details

**Name:** | **Relationship:**

**Phone:** | **Email:**

## Referrer Details

**Referrer Name:** | **Organisation:**

**Role:** | **Referral Date:**

**Phone:** | **Email:**

## Services Requested

Select all services relevant to this referral.

- ☐ Support Coordination - Level 2
- ☐ Psychosocial Recovery Coaching
- ☐ Early Childhood Keyworker / Educator
- ☐ Early Childhood Capacity Building Supports
- ☐ Allied Health / Therapy Assistant Supports
- ☐ In-Home Daily Living Supports
- ☐ Community Access & Social Participation
- ☐ Skill Development & Training
- ☐ Mentoring & Peer Support
- ☐ Capacity Building Group Sessions
- ☐ After-School Program - 3 pm to 6 pm
- ☐ Weekend Program - 9 am to 4 pm
- ☐ School Holiday Program - 9 am to 4 pm
- ☐ Transport / School Pick-Up & Home Drop-Off
- ☐ Respite / Overnight Supports
- ☐ Supported Independent Living (SIL)

**Other service / additional information:**

# PARTICIPANT SUPPORT PROFILE

Information to help us understand the participant

## Reason for Referral

Please describe the current situation, priorities and the support being requested.

## Disability, Health and Development

**Primary disability / diagnosis:**

**Secondary diagnoses / health conditions:**

**Developmental, mental health or psychosocial information:**

## NDIS Goals and Desired Outcomes

**Goal 1:**

**Goal 2:**

**Goal 3:**

Include the outcomes the participant and family would like to achieve through Frangipani Care.

## Strengths, Interests and Motivators

## Communication and Participation

Communication methods used:

- ☐ Verbal speech
- ☐ AAC device
- ☐ Sign / Key Word Sign
- ☐ Gestures / visual supports
- ☐ Interpreter required
- ☐ Communication plan attached

**Preferred communication and helpful strategies:**

## Daily Support Needs

- ☐ Personal care
- ☐ Meal preparation
- ☐ Medication prompts
- ☐ Mobility / transfers
- ☐ Transport
- ☐ Community safety
- ☐ Emotional regulation
- ☐ Social skills
- ☐ Routines / transitions
- ☐ Money / shopping
- ☐ Household tasks
- ☐ School / education support
- ☐ Employment / day program
- ☐ Sleep / overnight support
- ☐ Sensory regulation
- ☐ Positive behaviour support
- ☐ Technology / online safety
- ☐ Other

# HEALTH, SAFETY & SERVICE PREFERENCES

Please provide current plans and risk information where applicable

## Health and Safety Information

- ☐ Epilepsy / seizures
- ☐ Allergy / anaphylaxis
- ☐ Asthma / respiratory
- ☐ Diabetes
- ☐ Swallowing / choking
- ☐ Mobility / falls
- ☐ Aggression / property damage
- ☐ Absconding / wandering
- ☐ Self-injury
- ☐ Suicide / self-harm risk
- ☐ Infection control needs
- ☐ Other identified risk

**Medical conditions, medications, allergies and required health procedures:**

## Behaviour Support and Risk Management

☐ Behaviour Support Plan in place ☐ No Behaviour Support Plan ☐ Restrictive practices authorised / in use

**Behaviour Support Practitioner / Provider:**

**Known triggers, early warning signs and helpful de-escalation strategies:**

## Emergency and Clinical Contacts

**Emergency Contact:** **Phone:**

**GP / Clinic:** **Phone:**

**Preferred Hospital:** **Medicare / Health Info:**

## Service Preferences and Availability

**Preferred Start:** **Frequency:**

**Session Duration:** **Location:**

Available days: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Flexible

Support ratio: ☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ Group ☐ To be assessed

**Worker preferences / cultural, gender, language or accessibility requirements:**

# FUNDING, CONSENT & SUBMISSION

Complete the consent section before returning this referral

## NDIS Funding and Plan Management

Plan management type: ☐ Agency-managed ☐ Plan-managed ☐ Self-managed ☐ Other / pending

**Plan Manager:** **Phone:**

**Email:** **Relevant Budget:**

## Transport and Program Information

**Pick-Up Address:** **Drop-Off Address:**

**School / Program:** **Finish Time:**

**Transport, mobility, child restraint or vehicle requirements:**

## Documents Attached

☐ NDIS plan / goals ☐ Participant support plan ☐ Behaviour Support Plan

☐ Medication chart ☐ Health action plan ☐ Risk assessment

☐ Therapy / clinical reports ☐ Nominee / guardianship documents ☐ Other

## Consent to Share Information

I consent to Frangipani Care collecting and securely storing the information in this referral for intake, service planning and NDIS service delivery. I authorise Frangipani Care to contact the referrer, plan manager, support coordinator, school, health professionals and allied health providers named in this referral where reasonably required to assess and coordinate supports. Information will only be shared with consent, where required by law, or where there is a serious risk to health or safety.

☐ I consent to the collection and sharing of information as described above.

☐ I consent to Frangipani Care contacting relevant providers and supports.

☐ I consent to being contacted about transport and program arrangements.

## Signatures

**Participant / Nominee Name:** **Date:**

**Signature / Typed Name:** **Referrer Signature / Name:**

A typed name is accepted when the form is returned electronically.

## Office Use Only

**Date Received:** **Allocated To:**

**Outcome:** **Follow-Up Date:**

**Return completed referrals to admin@frangipanicare.com.au or call 0439 089 995**