MINDBRIDGE

Mindbridge Therapy and Coordination Services

Referral

Participant Information

Name: _____ **DOB:** _____

NDIS Number: _____

Current Address: _____

Contact number: _____

Nominee/Guardian name: _____

Nominee/Guardian contact number: _____

Referrer Information

Name: _____ **Contact No:** _____

Company: _____

Position: _____ **Email:** _____

Reason for Referral

- ☐ **Specialist Support Coordination**
- ☐ **Counselling**
- ☐ **Psychosocial Functional Capacity Assessment**
- ☐ **Housing Report**

Diagnosis

Primary Diagnosis _____

Secondary Diagnosis _____

Other physical health issues _____

Mandatory Safe Assessment (Please Circle)

Has the participant had suicide/self harm attempts? Yes No

If Yes – how recent? _____

Is there a criminal history/current legal actions pending? Yes No

If Yes – please detail _____

Is there history of violence? Yes No

If Yes – please detail _____

Is there any current AOD use? Yes No

If Yes – when was the last use? _____

How frequent? _____

Does the participant live with other people? Yes No

If Yes – please detail _____

Please note that Mindbridge only accepts Plan Managed or Self Managed NDIS plans. We can also charge fee for service.

Please acknowledge that participant/guardian is aware of referral and happy to proceed with Mindbridge services.

Referrer Name: _____

Signature: _____ Date: _____