### iCare Connections Referral Form

**REFERRER Details:**

|  |  |
| --- | --- |
| Referral date: |  |
| Name of Referrer: |  |
| Referrer’s Agency: |  |
| Postal Address: |  |
| Phone: |  |
| Email: |  |
| Client Consent: | I have obtained client verbal or written consent to make this referral. |

## **PARTICIPANT Details:**

Name of participant:

NDIS Number:

NDIS Plan Dates:

Address:

Ph:

Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_ Gender:

Marital status:

## **Referral Information:**

|  |  |
| --- | --- |
| Does the participant identify as:   * Aboriginal * Torres Strait Islander * CALD | Country of birth:  Language at home:  Primary Disability:  Secondary Disability:  Specify risk to self or others: |

## **Carer/Nominee/Advocate Details:**

Name:

Address:

Ph:

Gender:

## **Initial Support Needs information:**

|  |
| --- |
| Reason for referral: |
| Preferred Supports (gender, age, experience, tasks): |
| Current Supports in place: |
| Participant Strengths: |
| List Communication Support Needs and preferred communication method: |
| List Mobility Support Needs: |
| List Accommodation Needs: |
| List Behaviours of concern: |
| NDIS Plan Attached:  Yes  No Other: |

Please email this referral form along with the participants NDIS plan and any other relevant reports or assessments to [intake@icareconnections.com.au](mailto:intake@icareconnections.com.au).

Once received, it may take up to 48hrs to respond.

Thank you!