clear thinking MENTAL HEALTH GROUP
(03) 4343 1779
clearthinkingmhg.com.au

ndis REGISTERED PROVIDER

Behaviour Support Referral Form

Date: _____

Participant Details

Participant Name		Date of birth		Gender	
NDIS Number				Pronouns	
PACE	Is the participant on PACE?	❒ Yes ❒ No	If yes please refer to Endorsement section at the end of this form		
Plan Dates	Start		End		
Contact details	Home		Mobile		
Address					
Email address					
Language spoken at home		Interpreter required	❒ Yes ❒ No		
Preferred option for communication	❒ Email ❒ Post ❒ Phone	Do you identify as Aboriginal and Torres Strait Islander?	❒ Yes ❒ No		
Best contact for initial appointment booking		Does the participant need Easy Read documents	❒ Yes ❒ No		

Does this person require a deed? ❒ Yes ❒ No
If yes, please specify contact name and email

_____

Are there any court orders in place? ❒ Yes ❒ No

Alternative Contact Details (if participant is not primary contact)

Name of Alternative Contact				
Relationship to participant	❒ Parent ❒ Guardian ❒ Caregiver ❒ Other (please specify):			
Contact details	Home		Mobile	
Email address				

Next of Kin (Emergency) Contact Details (must be filled in, if different from above)

Name of emergency contact				
Relationship to participant	❒ Parent ❒ Guardian ❒ Caregiver ❒ Other (please specify):			
Contact details	Home		Mobile	
Email address				

Is there a Guardianship and/or Administration order in place? ☐ Yes ☐ No

Guardian Contact Details

Name	
Phone	
Email address	

Contact for Information Sharing (e.g., Reports and Assessments)

Please specify the authorised contact for sharing sensitive information:

☐ NOK ☐ Guardian

- **Next of Kin (NOK):** Generally, a family member listed as the emergency contact. However, the NOK may not be authorised to access confidential information unless they are also the legal guardian or have explicit written consent from the individual.
- **Legal Guardian:** A Legal Guardian is authorised to receive and share information related to the individual's care, including reports, and assessments. Ensure the guardian's authority is verified for privacy and confidentiality compliance.

Important: Information sharing must follow privacy and confidentiality policies.

Disability / Medical Conditions (including any diagnosis if relevant)

Disability	Is this disability/diagnosis recognised in the NDIS plan?

Participant's current address

	Start date:	

Key contacts

Title:	First name:	Last name:
Person type:	Person consulted, if other:	Consulted date:
Email:	Phone number:	

Title:	First name:	Last name:
Person type:	Person consulted, if other:	Consulted date:
Email:	Phone number:	

(If additional key contacts are involved, copy and paste another table)

Mealtime Management

Does the participant have a choking or swallowing difficulty? ☐ Yes ☐ No
If yes, is a Mealtime Management Plan in place? ☐ Yes ☐ No
Is the participant prescribed any antipsychotic, benzodiazepine or anti-epileptic medication?
☐ Yes ☐ No

Epilepsy Management

Does the participant have epilepsy? ☐ Yes ☐ No
If yes, is an Epilepsy Management Plan in place? ☐ Yes ☐ No

Plan Goals

Please attach or list the participant's current NDIS goals. These are essential for acceptance of referral

Additional Information

Current GP name		Phone:	
Involvement with other services	❒ Speech ❒ Physio ❒ OT ❒ Counsellor ❒ Social Worker ❒ Art Therapist ❒ Therapy Assistant ❒ Other (Please provide details below) _____	❒ Dietitian ❒ Podiatrist ❒ Orthoptist ❒ Audiologist ❒ Rehabilitation Counsellor ❒ Developmental Educator ❒ Music Therapist	
Additional relevant participant information			

Appointment Preferences

Preferred location ☐ Alfredton clinic ☐ Delacombe clinic ☐ Outreach/home visit ☐ Telehealth ☐ No preference

If outreach/home visits are requested, please complete the home-environment questions below.

Has there been any previous Risk Assessments for the home environment?	❒ No ❒ Yes (please provide copies with your referral)
Does the participant have pets?	❒ No ❒ Yes (please detail type of pet/s) _____
Are there other people living within the home environment?	❒ No ❒ Yes (please provide details)_____
Is there a history of aggression?	❒ No ❒ Yes (please provide details)_____

Clinician preference ☐ Female clinician ☐ Male clinician ☐ No preference
We will do our best to accommodate preferences; clinician availability and suitability may affect allocation.

Preferred days ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ No preference
Preferred times ☐ Morning ☐ Midday ☐ Afternoon ☐ After 4:00 pm ☐ No preference
Specific days, times or other scheduling needs: _____

_____

Behaviours of concern

Type	
Type	
Type	

Restraints*

Type	
Type	
Type	

Restrictive Practice/s

Are any restrictive practices currently in place? ☐ Yes ☐ No ☐ Unknown

Type	Details
Chemical Restraint	
Environmental	
Physical	
Mechanical	

Support Request Details

Support	Funding allocation (hours)
Specialist Behavioural Intervention Support 11_022_0110_7_3	
Behavioural Management Plan 11_023_0110_7_3	

Funding

☐ NDIA-managed ☐ Self-managed ☐ Plan-managed
If self-managed or plan-managed, please provide the invoicing contact details:

Name	
Email	

Funding Periods

Does the participant's plan have funding periods?

❒ Yes ❒ No

If yes, please provide the breakdown

My Provider Endorsement (PACE Participants Only)

While we understand participants are not obligated to endorse us as a My Provider, priority will be given to participants willing to endorse us as this streamlines NDIS administration processes.

Participants can endorse us via the following methods:

• By contacting their My NDIS Contact.
• Calling the NDIS National Contact Centre on 1800 800 110

The participant will require the following details for endorsement:

Trading Name: Clear Thinking Mental Health Group
Legal Name: The Trustee for The Holding Family Trust
Provider Number: 4050009546

How Did You Hear About Us?

❒ LAC recommendation ❒ Support Coordinator recommendation ❒ Friend recommendation
❒ Brochure ❒ NDIS register of Providers (online) ❒ CTMHG website
❒ Social media (e.g: Facebook) ❒ Search engine search (e.g: Google)

❒ Other (please provide details): _____

Referrer Details

Name:			
Phone number		Email	

I understand that:

- These records are owned by this organisation.
- Information in these records may be shared with staff within the organisation only when required for them to carry out their duties.
- I can ask to see records and receive a copy.
- Records are retained and archived in accordance with organisational policy and applicable legal requirements.
- I understand that all information obtained will be kept confidential.