clear thinking
MENTAL HEALTH GROUP

ndis REGISTERED PROVIDER

REFERRAL FORM (THERAPEUTIC SUPPORTS)

Date:

Participant Details

Participant Name		D.O.B		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 diagnosis recognised by the NDIS?

Mealtime Management

Is there a choking or swallowing problem ☐ Yes ☐ No
If yes, is there a Mealtime Management Plan in place ☐ Yes ☐ No

Is the participant on any antipsychotics, benzodiazepines or anti-epileptic medications
☐ Yes ☐ No

Epilepsy Management

Does the participant have Epilepsy? ☐ Yes ☐ No
If yes, does the participant have an Epileptic Management Plan ☐ Yes ☐ No

Plan Goals

***Please note goals listed within the NDIS plan 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 Type

☐ In Clinic ☐ Telehealth

☐ Outreach/Home Visits (please provide additional information 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 below)
Are there other people living within the home environment?	☐ No ☐ Yes (please provide details below)
Is there a history of aggression?	☐ No ☐ Yes (please provide details below)

Days Client Is ***NOT*** Available

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

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Support Request Details

Support	Funding Allocation (how many hours)
Assessment, Recommendation, Therapy and/or Training (Including AT) – Psychology 15_054_0128_1_3	
Assessment, Recommendation, Therapy and/or Training (Including AT) – Social Worker 15_621_0128_1_3	
Assessment, Recommendation, Therapy and/or Training (Including AT) – Art Therapist 15_610_0128_1_3	
Assessment, Recommendation, Therapy and/or Training (Including AT) – Other Professional 15_056_0128_1_3	
Therapy Assistant – Level 2 15_053_0128_1_3 (Applicable only when primary therapist is a CTMHG practitioner)	
Funding allocated for travel (hours)	

Funding

☐ NDIS Managed ☐ Self-Managed ☐ Plan Managed

If Self- Managed or Plan Managed, please provide details for invoices

Name	
Email	

Funding Periods

Does the 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 within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties.
- I can ask to see records and receive a copy.
- Records are archived for a set period according to policy and procedure.
- I understand that all information obtained will be kept confidential.