*Please complete this referral form in full.*

**FORM COMPLETED BY:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Phone: |  |
| Relationship to participant: |  | Date of referral: |  |

**PARTICIPANT DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: |  | Given name: |  |
| Identified gender: |  | Interpreter required: |  |
| Home address: |  |
| Email: |  | Home phone: |  |
| DOB: |  | Mobile phone: |  |
| Primary Diagnosis: |  | Do you identify as Indigenous, Aboriginal and/or Torres Strait Islander? | [ ]  Indigenous [ ]  Aboriginal [ ]  Torres Strait Islander[ ]  Not Applicable[ ]  Prefer not to answer  |
| Allergies: |  | Cultural background: |  |
| Living arrangements: |  |
| Additional information that would be helpful for the support worker: |  |
| Interests/Strengths: |  |

**Emergency contact person:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Relationship to participant: |  |
| Home phone: |  | Mobile phone: |  |
| Email: |  |

**NDIS DETAILS:**

|  |  |  |  |
| --- | --- | --- | --- |
| NDIS Number: |  | NDIS Plan attached: | [ ]  Yes [ ]  No |
| Plan start date: |  | Plan end date: |  |
| Do you have a Support Coordinator?*(if not listed above)* |  |
| Email: |  |

**RiskS/Hazards:**

|  |  |
| --- | --- |
| Are there any known risks or hazards that may pose harm to the participant or the visiting support worker? | [ ]  Yes [ ]  No |
| Please detail: |

**PLEASE SELECT THE BOX FOR EACH SUPPORT CATEGORY YOU WOULD LIKE TO APPLY FOR**

**Core Supports**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Support Requested | **Assistance with daily life** | **Assistance With Self-Care Activities** | [ ]  Yes [ ]  No |
| **Assistance With Personal Domestic Activities** | [ ]  Yes [ ]  No |
| **Assistance with social and community participation** | **Access Community Social And Rec Activities** | [ ]  Yes [ ]  No |
| How is the funding category managed? | [ ]  Plan [ ]  Self | Plan/Self manager details*(if applicable)*: |

**Capacity Supports**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Support Requested | **Increased social and community participation** | **Life Transition Planning Incl. Mentoring Peer-Support And Indiv Skill Develop****09\_006\_0106\_6\_3** | [ ]  Yes [ ]  No |
| **Skills Development And Training****09\_009\_0117\_6\_3** | [ ]  Yes [ ]  No |
| How is the funding category managed? | [ ]  Plan [ ]  Self | Plan/Self manager details*(if applicable)*: |

|  |  |
| --- | --- |
| Who to contact to discuss this referral? | [ ]  Participant [ ]  Referrer |

**Please attach copy of plan.**