Welcome to Able To Wellbeing. Please complete this form to refer a client. We aim to respond to you within 24 business hours. If you have any questions please email at [info@abletowellbeing.com](mailto:info@abletowellbeing.com)

**Participant/client details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth: |  |
| NDIS participant / Aged Care (AC) number: |  | Other client/reference number if relevant: |  |
| Home phone: |  | Mobile number: |  |
| Address: |  | | |
| Email address: |  | | |
| Salutation: | ☐ Miss ☐ Mr ☐ Mrs  ☐ Ms ☐ Dr ☐ Mx ☐ Other please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Gender you were assigned at birth: | ☐ Female ☐ Male ☐ Prefer not to say | | |
| Which gender most accurately describes you: | ☐ Man ☐ Woman ☐ Non-binary  ☐ Prefer not to say ☐ Other please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Which pronouns most accurately describe you: | ☐ She/Her ☐ He/Him ☐ They/Them  ☐ Other please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Marital status: | ☐ Single ☐ Married ☐ De Facto  ☐ Divorced ☐ Separated ☐ Widowed | | |

**Primary (next of kin) contact:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Home number: |  | Mobile number: |  |
| Address: |  | | |
| Email address: |  | | |

**Emergency contact: (please write ‘as above' if same as primary contact)**

Ideally, the emergency contact will be someone who lives locally to the participant/client so that in the even of an emergency or natural disaster, they are able to provide support.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Home number: |  | Mobile number: |  |
| Address: |  | | |
| Email address: |  | | |

**Other contacts:**

|  |  |
| --- | --- |
| Details of your NDIS / home care package provide: | Company name:  Care Manager / Support Coordinator name:  Email:  Phone:  Address: |
| Details of your doctor: | Company name:  Doctors name:  Doctors practice Email:  Phone:  Address: |

**For NDIS Participants, please answer the following questions:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Start date of NDIS plan: |  | | End date of NDIS plan: |  |
| How is the plan managed: | ☐ Self-managed ☐ NDIA managed ☐ Plan managed | | | |
| Will you pay for travel costs as per the NDIS Pricing Guideline? These costs will be discussed and agreed if applicable prior to the service delivery. | | ☐ Yes ☐ No | | |

**For Aged Care clients, please answer the following questions:**

|  |  |  |
| --- | --- | --- |
| Home care package level / funding program: | ☐ Level 1 – home care package  ☐ Level 2 – home care package  ☐ Level 3 – home care package  ☐ Level 4 – home care package  ☐ Short Term Restorative Care  ☐ Transition Care Program  ☐ DVA  ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| How is the plan managed: | ☐ Fully Managed by provider ☐ Self-managed  ☐ Co-managed (self-managed with a coordinator) | |
| Will you pay for travel? These costs will be discussed and agreed if applicable prior to the service delivery. | | ☐ Yes ☐ No |

**If you are a privately paying / fee-for-service client, please fill in this section:**

|  |  |
| --- | --- |
| Name of your Enduring Power of Attorney: |  |
| Please advise how you will pay invoices? |  |
| Name of person responsible for making payment |  |
| Email of person responsible for making payment |  |
| Phone of person responsible for making payment |  |
| Address of person responsible for making payment |  |
| Will you pay for travel? These costs will be discussed and agreed if applicable prior to the service delivery. |  |

**Other client information:**

|  |  |
| --- | --- |
| Allergies and symptoms (if none, please state ‘none'. | *e.g. morphine – vomiting* |
| How is it best to access your home? What access considerations are needed e.g. use side door and press bell: |  |
| Where is it best to park at your home? |  |
| In the event you do not answer the door or we are unable to access with a key, what emergency action would you like taken? |  |
| Do you have animals? If so can they be tied up / put into a room or outside during services to ensure staff safety and ability to do their role? |  |
| Are there any considerations for staff relating to the Participant / Client *e.g. triggers, physical or verbal aggression etc.?*   Please indicate support strategies for staff when working with the Participant / Client: |  |

***Referral details:***

|  |  |
| --- | --- |
| Please describe the services you are requiring Able To Wellbeing to perform? |  |
| Are services one-off or ongoing? If ongoing, please outline the estimated frequency and length of service. If unsure, or require Able To Wellbeing to advise an estimate post-assessment, please indicate: |  |
| Please indicate the approximate number of hours of services required (note: where services relate to assessments, the hours need to include time for report writing and any communication between stakeholders. If we do not think enough time is allocated, we will let you know and seek approval) |  |
| For NDIS clients, please list the item number/s. Please also indicate if travel will be paid: |  |

***Invoice information:***

|  |  |
| --- | --- |
| Address invoice to: |  |
| Name of company in which invoice is to be sent to: |  |
| Address of company invoice is to go to |  |
| Phone number of company invoice is to go to |  |
| Email of company invoice is to go to |  |

***Consent:***

|  |  |  |
| --- | --- | --- |
| Does the client/participant have a cognitive impairment or are they a child, which will require them to have a representative present during the service? | | ☐ Yes ☐ No  If yes, please complete below questions |
| Please provide name of the representative who will be present if applicable | |  |
| Please provide the email of the representative/s who will be present | |  |
| Please provide the phone number of the representative/s who will be present | |  |
| Would the client/participant like others involved in their care/assessments? If so, please provide the name, phone, email and relationship of the relevant person/s. | |  |
| Does the client/participant provide consent for the services | ☐ Yes ☐ No ☐ Representative has provided consent | |

***Any other information:***

|  |
| --- |
|  |