PARTICIPANT REFERRAL FORM

PART A: PERSONAL DETAILS		
First name:	**Surname:**	
Relationship to the participant	☐Family/ nominated representative. ☐Participant ☐Support coordinator ☐Other: specify	
Position		
Organisation		
Contact Number		
Email		
Are you able to sign documents on behalf of the NDIS Participant?	Yes ☐	No ☐

PART B: Participant Information			
First Name:		**Last Name:**	
Date of Birth			
NDIS Number			
Gender			
Religion			
Address:			
Mobile			
Email			

PARTICIPANT REFERRAL FORM

Living Arrangement	☐Alone ☐Family/Partner ☐Supported Accommodation ☐Other Describe:

NDIS Plan Details			
Plan Manager		Does the NDIS plan have funds?	
NDIS Plan Start Date		NDIS Plan End Date	

Diagnosis	
Primary Disability	
Secondary Disability	
Health Status	

Communication and Cultural Factors			
Language Spoken at Home		Preferred Language	
Country of Birth		Interpreter Required	☐Yes ☐No
Preferred method of communication	☐ Face-to-face ☐Phone ☐ Text message ☐ Email ☐ Visual (images/video) ☐ Letter ☐ Through my advocate/representative		
Other communication factors			
Other relevant cultural factors			

PARTICIPANT REFERRAL FORM

How can we assist your client, what services are they looking for?
Please fill details below…

Further Information	
Any risk that we need to know *(If yes, please specify below)*	
Participants strengths	
Any challenging behaviours that can assist our planning for your participant? *(If yes, please specify below)*	
Staffing preferences	

Likes:	**Dislikes:**

PARTICIPANT REFERRAL FORM

Safety Information		
Any risk of self-harm identified?	☐ Yes	☐No
Any harm from others identified?	☐ Yes	☐No
Any harm to others identified?	☐ Yes	☐ No
Are there any pets on the property?	☐ Yes	☐No
Are there any firearms being stored on the property?	☐Yes	☐No
Is there any history or current use of drugs at this property?	☐Yes	☐No

Information Sharing			
Role	Name and Contact	Engagement Preference	Limitations to Information Shared?
Emergency Contact	Name: Organisation: if relevant Contact:	**Frequency:** ☐Always ☐As needed. **Method:** ☐Email ☐Letter ☐Phone ☐In person	☐Yes ☐No. If yes, describe.
Legal Guardian	Name: Contact: Organisation: if relevant	**Frequency:** ☐Always ☐As needed. **Method:** ☐Email ☐Letter ☐Phone ☐In person	☐Yes ☐No. If yes, describe.
Pharmacist	Name: Contact: Organisation: if relevant	**Frequency:** ☐Always ☐As needed.	☐Yes ☐No. If yes, describe.

PARTICIPANT REFERRAL FORM

		Method: ☐Email ☐Letter ☐Phone ☐In person	
Local GP	Name: Contact: Organisation: if relevant	**Frequency:** ☐Always ☐As needed. **Method:** ☐Email ☐Letter ☐Phone ☐In person	☐Yes ☐No. If yes, describe.
Support Coordinator	Name: Contact: Organisation: if relevant	**Frequency:** ☐Always ☐As needed. **Method:** ☐Email ☐Letter ☐Phone ☐In person	☐Yes ☐No. If yes, describe.
Family/Friends	Name: Contact: Organisation: if relevant	**Frequency:** ☐Always ☐As needed. **Method:** ☐Email ☐Letter ☐Phone ☐In person	☐Yes ☐No. If yes, describe.