Participant Referral Form

Referrer Details:			
Date of Referral:		**Organisation:**	
Referred by:		**Position:**	
Phone:		**Email:**	
Does participant have Support Coordinator engaged?		☐ **Yes** ☐ **No** ☐ **N/A**	
If Yes, Support Coordination Agency:		**Support Coordinator Name:**	
Contact No.:		**Email:**	
If self-referral How did you hear about us?			

Participant Details:					
Name:				**D.O.B:**	
NDIS No.		**Plan Start Date:**		**Plan End Date:**	
Plan Management Type:	☐ NDIA Managed ☐ Plan Managed ☐ Self-Managed				
If Plan Managed (Plan Management Agency):					
Gender:	☐ **M** ☐ **F** ☐ **Other**		**Nationality:**		
Languages I Speak:				**Aboriginal or Torres Islander:**	☐ **Yes** ☐ **No**
Address:				**Suburb:**	
Postcode:				**State:**	
House Phone:				**Mobile No:**	
Email (if any):					
Participant is currently living in:	☐ **Home** ☐ **Hospital** ☐ **Another SIL facility** ☐ **YPIAC** ☐ **Other**				
Details:					
Discharge Date (if relevant):					
Participant main Carer is:		**Relationship:**			
Carer's Contact No.:		**Email:**			
Carer's Address is:		**Suburb:**			

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Postcode:		**State:**	
Does Carer require an interpreter?	☐ **Yes** ☐ **No**	**If Yes, Language?**	
Emergency Contact Person:		**Emergency Contact No.:**	
Relationship to Participant:		**Email (If any):**	
Referral Information:			
Support Service Required:			
Average hours required per week			
Expected Service Start Date		**Expected Service End Date (If any)**	
Primary Diagnosis:			
Secondary Diagnosis:			
Does the Participant have Epilepsy?	☐ Yes ☐ No		
Does the participant have any Mental Health Issues?		☐ Yes ☐ No	
If Yes, provide details:			
Other Health Concerns:			
Relevant Medical History:			
Current Medications:			
Other Information:			
Alerts/Precautions:			
Behaviours of concern:			
Does the Participant have a Behaviour Support Plan?	☐ Yes ☐ No		
If yes, who is the clinician involved?			

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Does the Participant have any Restrictive Practices?	☐ Yes ☐ No
If yes, what are they and has the practices been signed off by a Restrictive Practice Panel?	
What transportation / travelling requirements does the participant have?	
Are there any mobility issues?	☐ Yes ☐ No
If yes, please provide details.	
Does the Participant have a Risk Management and Behaviour Profile?	☐ Yes ☐ No
If yes, could you please provide details.	
Allergies:	☐ Yes ☐ No
If Yes please advise the following: **Reactions:** **Responses:**	
Likes:	
Dislikes/ Fears:	
Support required at night: *(if required OR for SIL participants)*	☐ Sleepover ☐ Active Night Support
Additional information:	