**Phone:** 0422 85 07 08
**Email:** enquiries@myconnectedcommunity.com.au

|  |
| --- |
| **Client Referral Form** |
| **CLIENT DETAILS** |
| Date of referral |  |
| **CLIENT NAME**  |  |
| Preferred Name |  | NDIS Number |  |
| Gender Identity |  | Date of Birth |  |
| Residential Address |  |
| Postal Address |  |
| Living Arrangementse.g., independent, supported |  |
| Cultural background |  | Primary language spoken at home |  |
| School/Workplace location |  | School/Workplace contact |  |
| **NOMINEE CONTACT DETAILS** |
| Nominee Name |  | Nominee Relationship |  |
| Nominee Phone |  | Nominee Email |  |
| Preferred contact method for Nominee | Phone | Text | Email |
| **CONTACT DETAILS FOR CLIENT (if separate to nominee)** |
| Client Phone |  | Client Email |  |
| Preferred contact method for Client | Phone | Text | Email |
| **SECONDARY CONTACT (EMERGENCY)** |
| Name |  | Relationship |  |
| Phone Number |  | Email |  |

|  |
| --- |
| **NDIS INFORMATION** |
| Diagnosis |  |
| Plan Dates |  |
| **SELF MANAGED** – Send invoices to: | **PLAN MANAGED** – Send invoices to: |
| **SERVICE REQUIREMENTS** |
| **Location** *EG: home, kindergarten, community location* |  |
| **Frequency** *EG: weekly / fortnightly* |  |
| **Preferred time or day for sessions** |  |
| **CLIENT GOALS** |
| *Please outline the focus for support. Please forward (or attach) a copy of NDIS plan goals.* |
| **REFERRER DETAILS** |
| Name |  | Organisation/Role |  |
| Phone Number |  | Email |  |
| **To ensure we are aware of factors which may impact service provision, please share relevant details below** |
| Is there a current/active Behaviour Support Plan for the participant?*\*\*A copy will be required prior to service.* | **YES** [ ]  | **NO** [ ]  |
| Are there any current/active court orders in place?*\*\*A copy may be required prior to service.* | **YES** [ ]  | **NO** [ ]  |
| Potential environmental issues for staff visiting the home? | **YES** [ ]  | **NO** [ ]  |
| Does the participant have any personal care requirements? | **YES** [ ]  | **NO** [ ]  |
| Does the participant have any alternative communication requirements? | **YES** [ ]  | **NO** [ ]  |
| Does the participant have any mobility requirements? | **YES** [ ]  | **NO** [ ]  |
| Does the participant have any medical conditions we should be aware of? | **YES** [ ]  | **NO** [ ]  |
| Are there any other factors we should be aware of prior to meeting with the participant? | **YES** [ ]  | **NO** [ ]  |
| Please add any further comments or information if relevant: |

Please email the completed form to enquiries@myconnectedcommunity.com.au