Favour and Care Referral form

Participant Details

Personal Details

Given Names: _____

Preferred Name: _____ Surname: _____

Gender: _____ Date of Birth: _____

Participant NDIS Details

NDIS Number: _____

NDIS plan start date: _____ NDIS plan end date:_____

Plan manager name: _____ Plan Manager tel: _____

Plan manager invoicing email address: _____

Contact Details

Address: _____

Postal Address (if different from above): _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

LGA: _____ Region: _____

Languages

Primary Language: _____

Interpreter Required: Y / N

Other Details

Birth Country: _____ Religion: _____

Indigenous Status: _____ Cultural Background: Y / N

Carer / Guardian Details

Given Names: _____

Surname: _____

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Relationship: _____

Mobile: _____Email:_____

Referrer details (if different from carer)

Name: _____

Surname: _____

Relationship: _____

Organisation: _____

Mobile:_____ Email:_____

Disabilities and Medical Information

Disabilities

Disability Type: _____

Medical Conditions/Allergies

Condition Name: _____

Type: Condition / Allergy

Triggers: _____

Treatment: _____

Condition Name: _____

Type: Condition / Allergy

Triggers: _____

Treatment: _____

Client has medication to be administered by **Our Organization**: Y / N

Most recent medication information contained in medication folders.

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Medical History

Does or has the participant suffered from any of the following?

- ☐ Asthma or any other lung complaint
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Heart Condition / Angina / High blood pressure
- ☐ Migraines
- ☐ Seizures
- ☐ Incontinence

If yes to any of the above please describe any possible triggers and the relevant medical care/response required: _____

Communication

Does the participant have the ability to communicate their needs? Y / N

If yes, how do they communicate?

- ☐ Verbal: _____
- ☐ Signing: _____
- ☐ Non-Verbal: _____
- ☐ Communication Aid: _____
- ☐ Responds to Yes/No Questions: _____
- ☐ Understands/Follows simple instructions: _____
- ☐ Does not respond: _____
- ☐ Other: _____

General Information

- ☐ Physical Restriction: _____
- ☐ Visual Impairment: _____
- ☐ Hearing Impairment: _____

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Type of Service Required

- ☐ Support coordination
- ☐ Respite day-time activities
- ☐ Overnight Respite
- ☐ Independent living skills
- ☐ Independent living programs
- ☐ School holiday activities
- ☐ Teen recreation and respite
- ☐ Day programs
- ☐ Employment
- ☐ In-home support

Behaviour

Behaviours that Our Organization should be aware of that may cause harm/injury to or threaten the safety of others: (*Please tick where applicable and add any comments that will assist **Our Organization** to provide the most appropriate support and care.)*

- ☐ Wanders – Needs full-time supervision: _____
- ☐ Offensive language/Verbally abusive: _____
- ☐ Anger management issues: _____
- ☐ Inappropriate sexual behaviour: _____
- ☐ Violent behaviour to others/self/property: _____
- ☐ Damages property: _____
- ☐ Fire lighting/risk: _____
- ☐ Other *(Please Specify)*: _____

Does the participant have any existing strategies to deal with the above? *(Please list)*

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Other Assistance

Does the person require assistance with toileting? Y/N

☐ Full assistance required ☐ Semi-independent ☐ Fully independent

Does the person have any special dietary requirements? Y / N

Access to Consumer File

I understand there are times when the CEO, Manager or Co-ordinator (or their relevant relievers) need to file documents relating to me or require access to information on my file that may assist with providing the best possible support and care.

Referrer signature: _____

Date signed: _____