

Referral for Support Services



| Participant Details | | | |
|--|------------------------------|-----------------------------|-------|
| Participant's Name | _____ | Date of Birth | _____ |
| Address | _____ | | |
| Telephone | _____ | Mobile Number | _____ |
| Email Address | _____ | Gender | _____ |
| Medical Diagnosis/Disability | _____ | | |
| Does the participant identify as Aboriginal, Torres Strait Islander? | _____ | | |
| Does the participant identify with a specific cultural/ethnic group? | _____ | | |
| Is an interpreter required? If yes, please list preferred language; | _____ | | |
| Would the participant like information on Advocacy Services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

| Parent / Guardian / Personal Responsible Details | | | |
|--|-------|---------------|-------|
| Name | _____ | Relationship | _____ |
| Address | _____ | | |
| Telephone | _____ | Mobile Number | _____ |
| Email Address | _____ | | |

| Referring Agent Details | | | |
|-------------------------|-------|---------------|-------|
| Name | _____ | Role | _____ |
| Organisation | _____ | | |
| Telephone | _____ | Mobile Number | _____ |
| Email Address | _____ | | |

| Funding Information | | | |
|---|---|---------------------------------------|--|
| NDIS | _____ | Other (please list) | _____ |
| NDIS Participant Number | _____ | | |
| NDIS Plan Dates | _____ | | |
| NDIS Plan is | <input type="checkbox"/> Agency/Portal Managed | <input type="checkbox"/> Plan Managed | <input type="checkbox"/> Self Managed |
| Does the participant have a | <input type="checkbox"/> Local Area Coordinator | <input type="checkbox"/> Plan Nominee | <input type="checkbox"/> Support Coordinator |
| | <input type="checkbox"/> Advocate | | |
| If so, please provide details | _____ | | |
| Does the participant give consent to share a copy of their NDIS Plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

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| Participant Support Goals | |
|---------------------------|-------|
| Goal 1: | _____ |
| Goal 2: | _____ |
| Goal 3: | _____ |

| Requested Supports (please tick) | | | |
|--|--------------------------|---|--------------------------|
| Home Based Support | <input type="checkbox"/> | PEEPS (After School Program; 3-6pm) | <input type="checkbox"/> |
| Community Based Support | <input type="checkbox"/> | PEEPS (School Holiday Program; 9-3pm) | <input type="checkbox"/> |
| Support Independent Living (SIL) | <input type="checkbox"/> | CAMPS | <input type="checkbox"/> |
| Social Leisure Inclusion Program (SLIP) - Autism Specific | <input type="checkbox"/> | Hydrotherapy Support (Support Worker level) | <input type="checkbox"/> |
| Support Coordination Services | <input type="checkbox"/> | | |

| Preferred Rostering Details | | | |
|-----------------------------|------------------|------------------|------------------|
| Monday | Tuesday | Wednesday | Thursday |
| Time: Duties: | Time: Duties: | Time: Duties: | Time: Duties: |
| Time: Duties: | Time: Duties: | Time: Duties: | Time: Duties: |
| Friday | Saturday | Sunday | |
| Time: Duties: | Time: Duties: | Time: Duties: | |
| Time: Duties: | Time: Duties: | Time: Duties: | |

| Participant Support Needs |
|--|
| <p>What is the participant's preferred method of communication?</p> <p> <input type="checkbox"/> Verbal <input type="checkbox"/> Augmented / Alternate Communication is used; including communication devices. <input type="checkbox"/> Non-Verbal </p> <p>Please provide details, if applicable;</p> <p>_____</p> <p>_____</p> <p>Please detail the participant's support needs, including any complex health needs or supports and/or any staff training/credentialing requirements?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |

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Participant Support Needs, continued.

Does the participant require any assistance with medication administration? If yes, please provide details including what level of assistance is needed and what is currently being prescribed.

Is a Medication Administration Record (drug chart) and Webster Pack available? Yes No N/A

Does the participant have any of the following, current Support Plans or documentation/reports?
Please note; Support Services cannot commence until all required supporting documentation is obtained.

- | | |
|---|---|
| <input type="checkbox"/> Asthma Management Plan | <input type="checkbox"/> Complex Health Plan |
| <input type="checkbox"/> Seizure Management Plan | <input type="checkbox"/> Occupational Therapy Plan / Report |
| <input type="checkbox"/> Meal Management Plan / Dietary Plan | <input type="checkbox"/> Speech Pathology Plan / Report |
| <input type="checkbox"/> Manual Handling Plan | <input type="checkbox"/> Bowel Care Management Plan |
| <input type="checkbox"/> Physiotherapy/ Exercise/Hydrotherapy Plans | <input type="checkbox"/> Allergy Management Plan; i.e. for Epi Pens |
| <input type="checkbox"/> Other; please list. | |

Does the participant, at times, show any signs of challenging behaviours? Yes No N/A
If yes, please provide details.

If applicable, is a Positive Behaviour Support Plan available, or is there a current referral in place for consultation with a Behaviour Support Practitioner?

Are there any identified restrictive practices that the referrer is aware of? If yes, please provide details.

Does the participant require any transport assistance, during rostered supports? If yes, please provide details.

Is the participant currently enrolled in school? If yes, please provide details.

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Participant Preferences

Does the participant identify any specific cultural, spiritual or religious beliefs that are important to them and may reflect how they wish supports to be delivered?

Does the participant have any interests and hobbies that they would like support staff to share with them?

Does the participant have any staffing preferences that would help in identifying the right staffing / support team?

General Queries

How did you hear about our Organisation and Services?

Is there anything further that the participant or the referrer would like to share?

Signature of Referrer: _____ **Date:** _____

Please return the completed Referral for Support Services, to the relevant regional office.

If you have any queries regarding the referral or our intake process, please do not hesitate to contact out Client and Family Services Team.

| | | |
|---|--|--|
| North 65 Amy Rd Newstead TAS 7250 Telephone: 03-6345-7308 Email: northcasecoordination@stgiles.org.au | North West 34 Alexander St Burnie TAS 7320 Phone: 03-6454-1222 Email: northwestcasecoordination@stgiles.org.au | South 11 Gant St Lenah Valley TAS 7008 Phone: 03-6238-1888 Email: southcasecoordination@stgiles.org.au |
|---|--|--|

Office Use Only

Referral Accepted Yes No Date Accepted / Declined _____ Referral Saved Yes