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? ☐ Yes ☐ 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 ☐ Agency/Portal Managed ☐ Plan Managed ☐ Self Managed

Does the participant have a ☐ Local Area Coordinator ☐ Plan Nominee ☐ Support Coordinator ☐ Advocate

If so, please provide details ____

Does the participant give consent to share a copy of their NDIS Plan? ☐ Yes ☐ No

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Participant Support Goals	
Goal 1:	
Goal 2:	
Goal 3:	

Requested Supports (please tick)			
Home Based Support	☐	PEEPS (After School Program; 3-6pm)	☐
Community Based Support	☐	PEEPS (School Holiday Program; 9-3pm)	☐
Support Independent Living (SIL)	☐	CAMPS	☐
Social Leisure Inclusion Program (SLIP) - Autism Specific	☐	Hydrotherapy Support (Support Worker level)	☐
Support Coordination Services	☐		

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

What is the participant’s preferred method of communication?

☐ Verbal ☐ Augmented / Alternate Communication is used; including communication devices. ☐ Non-Verbal

Please provide details, if applicable;

Please detail the participant’s support needs, including any complex health needs or supports and/or any staff training/credentialing requirements?

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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.

☐ Asthma Management Plan
☐ Seizure Management Plan
☐ Meal Management Plan / Dietary Plan
☐ Manual Handling Plan
☐ Physiotherapy/ Exercise/Hydrotherapy Plans
☐ Other; please list.

☐ Complex Health Plan
☐ Occupational Therapy Plan / Report
☐ Speech Pathology Plan / Report
☐ Bowel Care Management Plan
☐ Allergy Management Plan; i.e. for Epi Pens

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

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Referral Accepted ☐ Yes ☐ No Date Accepted / Declined ______ Referral Saved ☐ Yes