# NDIS REFERRAL

## REFERRAL FORM

| | | |
|---|---|---|
| **Referral Date** | | **Consumer or Parent/Guardian/Carer consent for this referral** (*If aged under 16):* ☐ Yes ☐ No |

## SUPPORT COORDINATOR DETAILS

| | | | |
|---|---|---|---|
| **Name:** | | **Organisation:** | |
| **Phone:** | | **Email** | |

## PLAN MANAGER DETAILS

| | | | |
|---|---|---|---|
| **Name:** | | **Organisation:** | |
| **Phone:** | | **Email** | |

## NDIS PLAN DETAILS

| | | | |
|---|---|---|---|
| **NDIS ID Number:** | | | |
| **NDIS Plan Attached** | ☐ Yes ☐ No | **NDIS Plan Ends** | |
| **Available Funding Amount for Requested Supports:** | | | |
| **NDIS Plan Goals relevant to this referral:** | | | |

## CONSUMER DETAILS

| | | | |
|---|---|---|---|
| **Name:** | | **Preferred Name:** | |
| **D.O.B:** | | **Gender:** | |
| ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither**<br>☐ **Culturally & Linguistically Diverse Background** | | | **Primary Disability:** |
| **Address:** | | | |
| **Phone Numbers:** | | | |
| **Email:** | | | |
| **Parent/Carer/ Guardian Name** *(If aged 12-18)* | | | |
| **Contact Details:** | | | |

## ADDITIONAL INFORMATION:

| | | | |
|---|---|---|---|
| **Reason for Referral:** | | | |
| **Consumer Goals and Hopes:** | | | |
| **Key Issues Identified by Consumer or Carer:** | ☐ Psychological support<br>☐ Physical health<br>☐ Housing/Accommodation<br>☐ Homelessness<br>☐ Employment | ☐ Substance use<br>☐ Relationships<br>☐ Domestic & Family Violence<br>☐ Social<br>☐ Education<br>☐ Isolation | ☐ Other: |
| **Mental Health Diagnosis:** *(If Applicable)* | | | |
| **Medication Details:** *(If Applicable)* | | | |
| **Outcomes/scores of any Relevant Psychosocial Assessments** *(e.g. K5, K10, SDQ)* | | | |
| **Risk of Harm to Self:** | Is the person currently Self-Harming | | ☐ Yes ☐ No |
| | Is the person at increased risk of suicide<br>**If assessed at high risk of suicide, please contact Emergency Services on 000, or go to the Hospital Emergency Department).* | | ☐ Yes ☐ No |
| **Are there any Risk Factors we should be aware of?** | ☐ Yes ☐ No | *If yes, please specify below or attach existing risk assessment:* | |
| **Other Services Consumer is accessing:** | | | |
| **Other Relevant Information:** *(If applicable please attach to this referral form)* | *E.g. Functional Capacity Assessment, Reports from other clinicians.* | | |

## SESSION DETAILS

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|---|---|---|
| **Preferred Location** | ☐ WWH Clinic ☐ Consumers Home ☐ Other: *Please provide details:* | |
| **Home Visit Risk Assessment** | Does the consumer live alone? | ☐ Yes ☐ No |
| | Are there any aggressive animals? | ☐ Yes ☐ No |
| | Is there any clutter or tripping hazards? | ☐ Yes ☐ No |
| | Does anyone at home have a history of violence? | ☐ Yes ☐ No |
| | Does anyone at home have any substance abuse? | ☐ Yes ☐ No |
| | Are there firearms in the home? | ☐ Yes ☐ No |
| | Does anyone at home have an infectious disease? | ☐ Yes ☐ No |
| | Is there mobile phone service at the home? | ☐ Yes ☐ No |
| | Will there be anyone else present at the home at the time of the session? *(If yes, please provide details)* | ☐ Yes ☐ No |
| | Are there any other risks that affect the clinician safety and wellbeing by accessing the property? | ☐ Yes ☐ No |
| | Is there a space for the clinician and consumer to meet privately? | ☐ Yes ☐ No |
| | **If any risks are identified, further assessment will be conducted prior to the home visit.** | |

## CONSUMER PREFERENCES

| | | | |
|---|---|---|---|
| **Preferred Gender of Worker** | ☐ Don't Mind ☐ Male ☐ Female | | |
| **Preferred Contact Methods** | *Okay to leave voicemail/send SMS: | | ☐ Yes ☐ No |
| | ☐ Mobile<br>☐ Home Phone | ☐ Email | ☐ via Referrer |
| | *If we can't reach the consumer, do they consent to a home visit? | | ☐ Yes ☐ No |
| | *Is it okay to leave a letter/card at home? | | ☐ Yes ☐ No |
| **Other Preferences:** | | | |

**Please send Referral form to Wakai Waian Healing by either of the following Means:**

**Email:** NDIS@wakai-waian.com.au
**Postal:** Wakai Waian Healing, PO Box 4080 Rockhampton QLD 4700.

**For more information:**
Freecall: 1800 732 850 (Choose 4 for NDIS)