**Recovery Plus – Referral Form**

Referral Form for NDIS Participants

Please send the completed form to: [referral@recoveryplussupport.com.au](mailto:referral@recoveryplussupport.com.au)

Please attach a copy of the NDIS plan to this document

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| **PARTICIPANT DETAILS:** | |
| **First Name:** Click or tap here to enter text. | **Last Name:** Click or tap here to enter text. |
| **Date of Birth:** Click or tap here to enter text. | **NDIS Number:** Click or tap here to enter text. |
| **Gender:**  Male  Female  Other | **Address:** Click or tap here to enter text. |
| **Contact Number:** Click or tap here to enter text. | **Email:** Click or tap here to enter text. |
| **Emergency Contact:** Click or tap here to enter text. | **Relationship to NDIS Participant:** Click or tap here to enter text. |
| **Contact Number:** Click or tap here to enter text. |
| **Date of the Referral:** Click or tap here to enter text. | |

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| **LIVING ARRANGEMENT:** | |
| **Alone** | **Family/ Partner** |
| **Supported accommodation** | **Other** (Please specify) Click here to enter text. |

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| **NDIS PLAN DETAILS:** | |
| **Plan Manager Details:** Click or tap here to enter text. | |
| **NDIS Plan Start Date:** Click or tap here to enter text. | **NDIS Plan End Date:** Click or tap here to enter text. |

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| **DETAILS OF INDIVIDUAL MAKING REFFERAL:** | |
| **Name:** Click or tap here to enter text. | **Organisation:** Click or tap here to enter text. |
| **Position:** Click or tap here to enter text. | **Address:** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | **Contact Number:** Click or tap here to enter text. |
| **Are you able to sign documents on behalf of the NDIS Participant?** | Yes  No |

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| **PARTICIPANT’S DISABILITY:** | |
| **Primary Disability:** Click or tap here to enter text. | **Secondary Disability:** Click or tap here to enter text. |

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| **LEVEL OF SUPPORT REQUIRED:** *(Please tick appropriate boxes)* | | | | | |
|  | **Dependant** | **Needs some Assistance** | **Independent with use of Aids/Equipment** | **Independent** | **Not Applicable** |
| **Mobility:** |  |  |  |  |  |
| **Self-Care:** |  |  |  |  |  |
| **Mealtime Assistance:** |  |  |  |  |  |
| **Domestic Tasks:** |  | **‘** |  |  |  |
| **Community Access:** |  |  |  |  |  |
| **Communication:** |  |  |  |  |  |

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| **SERVICES REQUIRED:** |
| *Please fill details below…*  Days of support:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday  Flexible Weekdays  Time of support:  AM  PM  Flexible times |
| *Please fill details below…*  Click or tap here to enter text. |

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| **SAFETY INFORMATION:** | |
| **Any risk of self-harm identified?** | Yes  No |
| **Any harm from others identified?** | Yes  No |
| **Any harm to others identified?** | Yes  No |
| **Are there any pets on the property?** | Yes  No |
| **Are there any firearms being stored on the property?** | Yes  No |
| **Is there any history or current use of drugs at this property?** | Yes  No |

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| **FURTHER INFORMATION:** |
| **Any risk that support staff need to know** *(If yes, please specify below)*  Click or tap here to enter text. |
| **Does the participant display any challenging behaviours?** *(If yes, please specify below)*  Click or tap here to enter text. |
| **How did you hear about Recovery Plus Support?**  Click or tap here to enter text. |

Important note: While Primacy Care Australia does our best to ensure the best fit for a participant is chosen, it is our priority that we provide service as soon as possible to support the needs of a participant with urgency.