|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Participant details** | | | | | | | | | | | | | | | | | | | | |
| Full name: | |  | | | | | | | | | | | | Participant NDIS Number: | | | | | |  |
| Date of birth: | | | | | DD / MM / YYYY | | | | | | | | | | | | | | | |
| Mobile: | |  | | | | | | | | | | | | | Phone: | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | |
| My advocate/representative: *(name & number)* | | | | | | | | | | | |  | | | | | | | | |
| Alternative contact person: *(if different)* | | | | | | | | | | | |  | | | | | | | | |
| How Plan is managed: Plan Managed  Self-Managed  NDIS Managed  Other: | | | | | | | | | | | | | | | | | | | | |
| Plan Manager: Name / Organisation: Phone / Email: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Mode of communication** | | | | | | | | | | | | | | | | | | | | |
| Language: | | |  | | | | | | | | Preferred Language spoken: | | | | | | | |  | |
| Interpreter required: | | | | | | | | | Yes  No | | | | | | | | | | | |
| Preferred method of communication: | | | | | | | | | | | |  | | | | | | | | |
| face to face | | | | | | | | | | phone call | | | | text message | | | | | email | |
| letter | | | | | | | | | | visual (images/videos) | | | | contact with my advocate/representative | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Engagement preferences** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | With who | | | How  *(mode of engagement)* | | | | | How often | | |
| family | | | | | | | | | |  | | |  | | | | |  | | |
| friends | | | | | | | | | |  | | |  | | | | |  | | |
| community | | | | | | | | | |  | | |  | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Diversity and cultural background** | | | | | | | | | | | | | | | | | | | | |
| Country of Birth: | | | | | | |  | | | | | | | | | | | | | |
| Aboriginal | | | | | | | | | | Torres Strait Islander | | | | Neither | | | | | Both | |
| Refugee | | | | | | | | | | Asylum Seeker | | | | Neither | | | | |  | |
| Religion: | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Type of disability: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Current health status: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Summary of the Participants strengths, goals, concerns | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Provider details (referral to/from)** | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | |
| Phone: |  | | | | | | | | | | | | | Email: | |  | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | |
| Postal address: | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Referral details** | | | | | | | | | | | | | | | | | | | | |
| Date of referral: | | | | | | | | DD / MM / YYYY | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Type of Support Required: | | | | | | | | | | | | | | | | | | | | |
| Assistance with personal activities  Personal activities (High intensity)  Household tasks  Assistive technology and Equipment  Community access  Specialized Disability Accommodation (SDA)  Assist-life stage, Transition  Support Independent Living (SIL)  Self-Directed services and supports  Respite ONLY  Group/centre activities  Community Nursing  Development-life skills  Support Coordination  Daily tasks / shared living  Specialist Support Coordination | | | | | | | | | | | | | | | | | | | | |
| Summary of the referral reasons | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Sign off** | | | | | | | | | | | | | | | | | | | | |
| Participant: | | | | | |  | | | | | | | | | Signature: | |  | | | |
| Date: | | | | | | DD / MM / YYYY | | | | | | | | |
| Provider:  *(referral to/from)* | | | | | |  | | | | | | | | | Signature: | |  | | | |
| Date: | | | | | | DD / MM / YYYY | | | | | | | | |
| **Companion Mental Health and Disability Services Pty Ltd** | | | | | | | | | | | | | | | Signature: | |  | | | |
| Date: | | | | | | DD / MM / YYYY | | | | | | | | |