|  |
| --- |
| **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 |