NDIS - Referral Form

Date of Referral: _____ Referred by: _____

SUPPORT PURPOSE	DOMAIN	SUPPORT CATEGORIES	Mark Box
CAPACITY BUILDING SUPPORTS	CHOICE & CONTROL	Support Coordination (07)	☐
	CHOICE & CONTROL	Psychosocial Recovery Coaching (07)	☐
CORE SUPPORTS	SOCIAL AND COMMUNITY PARTICIPATION	Participation in Community, Social, and Civic activities (04)	☐
		Transport (02)	☐
	DAILY LIVING	Daily Personal Activities (01)	☐
		Supported Independent Living (01)	☐
		Short-term Accommodation (01)	☐
		Medium-term Accommodation (01)	☐
		Respite (01)	☐
		Assistance with Household Tasks (01)	☐

Referring Organisation/Coordinator of Supports Details			
Organisation Name:			
Contact Person:		Relationship to Participant:	
Contact Details:	W:	M:	E:

Client Details			
Family Name:			
Given Name/s:			
NDIS Number:		NDIS Plan Dates:	
Date of Birth:		Gender:	
Home/Street Address:			
Postal Address:			
Legal Guardian Name and Contact:			
Emergency Contact Information:			
Client's Diagnoses: *(if applicable)*			
Ethnicity:			
ATSI Status	☐ Aboriginal ☐Torres Strait Islander ☐Both ☐Neither		
Language(s) spoken:			

Does the client have any current or past medico-legal or forensic issues?	
Does the client have a history of self-harm or suicidal thoughts or attempts?	
Does the client have a history of violent behaviour or sex offences	
Does the client experience violence in the home?	
Does the client have stable and safe accommodation?	
Does the client have their basic needs met including food security?	

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Does the client have a stable financial situation?	
Does the client have a previous or current psychiatric diagnosis?	
Are there any other mental health or behavioural issues that might impact on the client's ability to engage with therapy?	
If yes please describe and/or attach Behaviour Support/Management Plan:	

Funding		
Therapy/Respite will be funded by		
Fund Management Type	Management Type:	
	Management Organisation:	
	Phone:	
	Email:	
Approval Provided		
Support Level of Care (please circle)	LOW	MEDIUM HIGH

Brief reason for referral (please include therapy goals):

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Please provide information about the client to assist TK Community Care to provide the best care to the participant (please include Care Plan, Behaviour Support Plan, Occupational Therapy Report/s etc. if available):

Please complete this form (preferably electronic) and email to: enquiry@tkcommunitycare.com.au
You will receive a response within 24-48 business hours.