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| **Confidential Referral for an Assessment Report: NDIS application or Plan review** |

# Person making the referral

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Organisation |  |
| Telephone |  |
| Email |  |
| Postal address |  |
| Date of referral | /     / |

# Client name

|  |  |  |  |
| --- | --- | --- | --- |
| Client name |  | | |
| Age |  | **D.O.B** | /     / |
| Address |  | | |
| Gender |  | | |
| Country of Birth |  | | |

# Primary contact person (if applicable).

|  |  |
| --- | --- |
| Name |  |
| Relationship to participant |  |
| Address |  |
| Telephone |  |
| Email |  |

# Other relevant persons and contact details

(E.g., family member, legal guardian, service provider contact etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Role | Telephone | Email |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# About the client

## Primary disability (choose the single most appropriate)

|  |  |
| --- | --- |
| Intellectual or cognitive (please describe below ) | Brain injury (TBI or ABI) |
| Autism Spectrum Disorder (ASD) or related (e.g: Landau-Kleffner, Williams, Rett’s, Prader Willi, Angelman) | Physical or Sensory (Please describe below) |
| Neurological disorders (e.g. Cerebral Palsy, Multiple Sclerosis, Epilepsy, Huntington's disease), specify: | Psychiatric disability |
| Other (specify): | |

## Secondary disabilities (list and/or describe all)

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|  |

## Other medical/health conditions (or attach a current medical summary)

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## Activity and participation

Please indicate the level of help or supervision required for each life area by ticking only one level of help assistance (help) or supervision that the participant typically requires in their day-to-day life. Always assume usual aides and equipment are present.[[1]](#footnote-1)

|  |  |  |
| --- | --- | --- |
| Self-care e.g. washing oneself, dressing, eating, toileting | | |
| Always needs help/supervision | Sometimes needshelp/supervision | Needs no help/supervision – with or without aids |
| Mobility e.g. moving around the home and/or moving around away from home (including using public transport or driving a motor vehicle), getting in or out of bed or a chair | | |
| Always needs help/supervision | Sometimes needshelp/supervision | Needs no help/supervision – with or without aids |
| Communication e.g. making oneself understood, in own native language or preferred method of communication if applicable, and understanding others | | |
| Always needs help/supervision | Sometimes needshelp/supervision | Needs no help/supervision – with or without aids |
| Provide an overview of the activities in which the person is engaged in (e.g. day services, community access, work): | | |
| Other comments (if needed): | | |

# Attachments

Please attach informative documents e.g., past clinical reports, assessments, current NDIS plan etc.

|  |  |
| --- | --- |
| No. | Description |
|  |  |
|  |  |
|  |  |

# NDIS information

## For NDIS participants only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant No. |  | | | |
| NDIS Plan dates | Start | /     / | End | /     / |

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Thank you for your time in completing this referral. Connect health will contact you shortly.

# Internal use only

|  |
| --- |
| Date referral received: |
| Action: |

Please return to:

Intake Connect health & community

2A Gardeners Road, Bentleigh East Vic 3165

or email to:

[Intake@connecthealth.org.au](mailto:Intake@connecthealth.org.au)

Enquiries: Jean Magar, Program Manager, Phone 9575 5387

1. Adapted from Anderson, P., & Madden, R. (2011). Design and quality of ICF-compatible data items for national disability support services. *Disability & Rehabilitation, 33*(9), 758-769. [↑](#footnote-ref-1)