Referral Form – Disability Services

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Participant Name  | enter text | D.o.B | Enter date | Gender | enter text |
| Contact Details  | Home  | enter text | Mobile | enter text |
|  |  |  |  |  |
| Email Address | enter text |
| Language Spoken at Home  | enter text | Interpreted Required | [ ]  Yes [ ]  No |
|  | Do you Identify as Aboriginal and Torres Strait Islander | [ ]  Yes [ ]  No |
| Preferred Option for Communication  | [ ]  Email [ ]  Phone [ ]  Post  |
| Residential Address  | enter text |
| *(if different from above)*Postal Address  | enter text |

Is there a Guardianship and/or Administration order in place? [ ]  Yes [ ]  No

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Parent/Guardian/Care Giver | enter text | Lives with Participant  | [ ]  Yes [ ]  No |
| Emergency Contact  | [ ]  Yes [ ]  No |
| Relationship to participant  | [ ]  Parent  | [ ]  Guardian  | [ ]  Care Giver  | Other |  |
| Residential address  | enter text |
| *(if different from above)*Postal Address | enter text |
| Contact details  | enter text |
| Email address | enter text |

# Disability/ Psychosocial /Medical condition Including any diagnosis

|  |  |
| --- | --- |
| 1. | enter text |
| 2. | enter text |
| 3. | enter text |

# Participant health concerns and how to escalate urgent health situations

|  |  |
| --- | --- |
| 1. | enter text |
| 2. | enter text |
| 3. | enter text |

|  |  |
| --- | --- |
| NDIS Number  | enter text |
| NDIS Plan Dates | enter text |  [ ]  Self-Managed  | [ ]  Plan Managed | [ ]  NDIS Managed  |
| Mobility Issues | enter text |
| Cultural/Religious Requirements  | enter text |
| Other Considerations  | enter text |
| Preferred Mode of communication | enter text |

# A bit about me

|  |
| --- |
| enter text |
| Goals and Aspirations  | enter text |
| What would you like to achieve for yourself  | enter text |
| Short Term  | enter text |
| Long Term  | enter text |
| Support Required  | enter text |
| (Include type and duration) | enter text |
| Preferred support days/times/gender | enter text |

**I understand that:**

* These records are owned by MercyCare
* Information within these records will be shared with other staff within the MercyCare on and only when staff require the information to carry out their duties
* I can ask to see records and receive a copy
* Records are archived for a set period according to policy and procedure
* I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

|  |  |
| --- | --- |
| **Signature of** **Participant/Parent/Guardian/ Referrer**  | enter text |
| **Name** | enter text |
| **Date** | Enter date |
| **Relationship to Participant**  | enter text |