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 | |