Crest Support

REFERRAL FORM

PERSONAL INFORMATION

Person Referring :

Date of Referral : ____/____/____

Referring Agency : _____ **Phone** : _____

Reason for referral : _____

Where did you hear about us? : ☐ Web ☐ Previous Contact ☐ Word of Mouth ☐ Other

PARTICIPANT INFORMATION

First and last Name (if different from above) :

Date of Birth : ____/____/____

Gender : ☐ Male ☐ Female ☐ Transgender ☐ Other

NDIS Number : _____ **NDIS Plan dates** : _____

Support Person/Advocate : _____

Address : _____

NDIS Plan manager details : _____

Mobile : _____ **Home Phone** : _____

Email : _____ **Work Phone** : _____

Marital Status : _____ **Australian Resident** : ☐ Yes ☐ No

Country of Birth : _____ **Nationality** : _____

Indiginous Status : _____

Next of Kin/Carer : _____ **IPhone** : _____

Language at home : _____ **Interpreter required** : ☐ Yes ☐ No

Does the Consumer have decision making assistance? : ☐ Yes ☐ No

Informal Decision Maker contact details : _____ **Areas of Decision Making** : _____

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Public Trustee Contact Details : _____ **Areas of Decision Making** : _____

Power of Attorney Contact Details : _____ **Areas of Decision Making** : _____

Enduring Power of Attorney Contact Details : _____ **Areas of Decision Making** : _____

Adult or Appointed Guardian : _____ **Copy of order availble?** : ☐ Yes ☐ No

Contact details : _____ **Areas of Decision Making** : _____

PARTICIPANT CONDITIONS

Does the participant have any physical Health Conditions? : ☐ Yes ☐ No

If Yes please list : _____

Does the participant have any Mental Health Conditions? : ☐ Yes ☐ No

If Yes please list : _____

GP : _____ **Treating Specialist** : _____

Case Manager : _____ **Work Phone** : _____

Does the participant have any Cognitive Disability? : ☐ Yes ☐ No

Does the participant have any access to funding? : ☐ Yes ☐ No

Name Source : _____

Does the participant have an Individual Funding Package? : ☐ Yes ☐ No

Does the participant have any Behaviours of Concern? : ☐ Yes ☐ No

If Yes, please describe them :

Does the participant have an approval for Restrictive Practices? : ☐ Yes ☐ No

If yes, please provide expiry date : _____/_____/_____

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PARTICIPANT CONDITIONS

Does the participant have a Positive Behavioural Support Plan? : ☐ Yes ☐ No

If Yes, please detail :

Alerts/Risks/ Precautions :

Current Community Supports :

Type of Accomodation : For example Own Home, Renting, caravan, retirement Village, Hostel.

Additional Information I.E Webster packs, medication management, feeding assistance, communication :

REQUIREMENTS ONGOING

What Support/assistance is the participant looking for? :

I,_____ give my consent for this Intake form to be passed on to the staff at Crest Support.

Signature : _____

Date : _____/_____/_____