Referral Form – National Disability Insurance Scheme (NDIS)

Please complete this referral form below and forward to our team at communitycare.nsw@mcarthur.com.au
If you have any questions, please contact our Community Care team on 02 9277 7000

Date of Referral: Date of Appointment:

Participant Details

Full Name:

Gender: ☐ Male ☐ Female Date of Birth:

Address:

Postal Address:

Contact Number: Home: Mobile:

Email:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Is the Participant of Aboriginal or Torres Strait Islander decent? ☐ Yes ☐ No

If yes, would the participant prefer to be linked in with an ATSI specific agency? ☐ Yes ☐ No

Language Spoken: ☐ English ☐ Another language (……)

Interpreter Required: ☐ Yes ☐ No

Primary Disability:

Primary Carer/ Next of Kin/ Guardian/ Emergency Contact Details

Full name: Relationship to the Participant:

Address:

Contact Number: Email:

Plan Details

NDIS Participant Number: NDIS Contact Name:

Plan Start Date: Plan End Date:

Plan Management Provider: Plan attached: ☐ Yes ☐ No

Invoice Contact Number: Invoice Email:

Support Coordinator/ Referrer Details

Full Name: Organisation:

Address:

Contact Number: Email:

Referral Information

Information about the participant (interests, dislikes):

Formal diagnosis, medical information and allergy alerts:

Living Situation

☐ Own home/ living alone ☐ Own home/ with family member or others ☐ Residential care/ nursing home/ SRS/ CRU ☐ Others, please specify (……..)

Comments: (i.e.: pets):…….

Cognition

☐ Very good ☐ Good ☐ Fair ☐ Poor

Comments: ……..

Communication

☐ Verbal ☐ Non-verbal ☐ Aids ☐ Others, please specify (……)

Comments: ……..

Mobility

☐ Independence ☐ Assist ☐ Walking stick ☐ Walking frame

☐ Manual hoist ☐ Shower chair ☐ Wheelchair ☐ L frame

☐ Ceiling hoist ☐ Others, please specify (……)

Personal Care

	No support required	Verbal prompt	Physical assistance
Shower/ Bathing	☐	☐	☐
Toileting	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐

Comments: ……..

Does the participant have a BSP? ☐ Yes. If so, please attach (……) ☐ No

Shift commencement date _____ Core support maximum funding: _____

Transport support: ☐ Yes If yes, please select ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ No

Shift routine

Carer preference (e.g.: male/female)

Carer skills required

☐ Medication ☐ Bowel care ☐ Epilepsy ☐ Behaviour experience

☐ Peg feeding ☐ Catheter ☐ Diabetes ☐ Car for transport

☐ Hoist ☐ Condom drainage ☐ Dementia ☐ Full licence

Other relevant information