Custom Care & Accommodation - Participant Referral Form

Please complete and return to jay@customcareaccommodation.com

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| --- | --- |
| **Has the Participant given consent to share their information with us?** | Yes  No |

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| **Participant Name:** | |  | | | | **Date of birth:** | |  |
| **Email:** | |  | | | | **Phone:** | |  |
| **Address:** | |  | | | | | | |
| **Gender:** | Male | | Female |  | **Preferred Pronouns:** | | |  |
|  | Other: | |  |  | **Identifies as LGBTQIA+:** | | | Yes  No |
| **Cultural background:** | | |  |  | **Aboriginal or Torres Strait Islander Origin:** | | | |
| **Preferred language:** | | |  |  | Yes, Aboriginal | | No | |
| **Requires interpreter:** | | | Yes  No |  | Yes, Torres Strait Islander | | | |

**This referral is for program:**

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|  | **Independent Living (NDIS)** |  | Participant NDIS No: |  | |
|  | Does participant have NDIS funding? | | Yes. Funding ratio: |  | No |
|  | What funding type will be used? | | SIL (Supported Independent Living)  ILO (Individual Living Options)  STA (Short Term Accommodation)  MTA (Medium Term Accommodation)  Other: Please specify | | |

| ***Please tick all that applicable to the Participant*** | | | | **Yes** | **No** |
| --- | --- | --- | --- | --- | --- |
| History of violence / harmful behaviours including verbal/physical aggression. | | | |  |  |
| Does the person have complex behaviours that may cause harm (physically/psychologically) to staff? | | | |  |  |
| Does the person have complex behaviours that may cause harm (physically/psychologically) to others? *(e.g.: other participants, visitors, etc.)* | | | |  |  |
| Does, or has, the person been known to use drugs or has substance abuse? | | | |  |  |
| Has the person been convicted of an offense and/or alleged crime in the last 6 months? | | | |  |  |
| Does the person have complex medical conditions which requires assistance to manage? *(e.g., asthma, diabetes, catheters, ventilators, etc.)* | | | |  |  |
| Has the person had any medical episode resulting in hospitalisation in the last 6 months? | | | |  |  |
| Does the person have regulated restrictive practice that are documented in their Behaviour Support Plan? | | | |  |  |
| Select below risks that are associated with the person. | | | |  | |
| Self-harm / suicidality  Property damage  Absconding  Has a pet | | 2 or more medical conditions  Excessive alcohol consumption  Abuse from others (physical/financial)  Homelessness | |
| Select below medication risks that are associated with the person? | | | |  | |
| 5 or more medications  Medication non-compliance | | Mental Health Treatment Order | |
| 1 = Very confident | 5 = Somewhat | | 10 = Not at all |

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| **Detailed information about participant’s background** *(e.g.: who they are, where they come from, their family situation, etc.)* |
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| **Additional supports required:** |
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| **Needs and Requirements** *(please tick all that applicable)* | |
| --- | --- |
| Overnight active support  Intensive domestic support  Specialised transport | Assistant with manual handling  Specialised mobility equipment  Specialised trained staff *(BSP, diabetes, catheter, etc.)* |

| **Supporting Documents** | Attached | Not Attached | Not Applicable |
| --- | --- | --- | --- |
| NDIS Plan | Yes | No | N/A |
| Behaviour Support Plan | Yes | No | N/A |
| Therapeutic Care Plan | Yes | No | N/A |
| GP Management Plan | Yes | No | N/A |
| Mental Health Treatment Plan | Yes | No | N/A |
| Functional Assessment *(Occupational Therapist, Behaviour Specialist, etc)* | Yes | No | N/A |
| Complex Health Care Plan *(complex wound, diabetes, dysphagia, epilepsy, meal management, etc.)* | Yes | No | N/A |
| Information from other service providers | Yes | No | N/A |
| **Other documents** *(please provide details)* | | | |
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| **Referrer name:** |  | **Relationship:** |  |
| **Email:** |  | **Phone:** |  |
| **Address:** |  | **Organisation:** |  |
| **Signature:** |  | **Date:** |  |