Custom Care & Accommodation - Participant Referral Form

Please complete and return to jay@customcareaccommodation.com

|  |  |
| --- | --- |
| **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)* |
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| [ ]  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:** |  |