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| **Uniting Referral Form - NDIS**  Email: [uniting.referral@vt.uniting.org](mailto:uniting.referral@vt.uniting.org) Contact: 1300 277 478 | | | | | | | |
| **Consumer DETAILS** | | | | | | | |
| Given Name: | | Surname: | | | | Preferred name: | |
| DOB: | | | Date of referral: | | | | |
| Residential Address: | | | | | | | |
| Telephone: (Home) | | | | (Mobile) | | | |
| Email: | | | | | | | |
| Country of birth: | | | | Preferred language: | | | |
| Identifies as Aboriginal/Torres Strait Islander:  Yes  No | | | | Interpreter required:  Yes  No | | | |
| **LIVING STATUS** | | | | | | | |
| Type of Residence:  Home  Aged Care Facility  SDA  SIL  other | | | | | | | |
| Living alone? :  Yes  No | | | | | | | |
| Access to Home (i.e. Parking on street): | | | | | | | |
| Home Risk Assessment – please specify if you are aware of any issues that may impact on the consumer or service provider safety. | | | | | | | |
| **EMERGENCY CONTACT** | | | | | | | |
| Name: | | Contact: | | | | Relationship: | |
| Carer  Home supervisor (SIL) | | Name: | | | | Phone: | |
| **AUTHORISED REPRESENTATIVES** | | | | | | | |
| EPoA – medical  EPoA – financial  Guardian  Administrator | | | | | | | |
| Name: | | | | Contact: | | | Relationship: |
| **GP DETAILS** | | | | | | | |
| Name: | | | | Contact: | | | |
| Clinic Address: | | | | | | | |
| **FUNDS MANAGEMENT** | | | | | | | |
| How are the Participant’s funds managed?  NDIA  Plan Managed  Self-Managed | | | | | | | |
| **PLAN NOMINEE DETAIL OR SUPPORT COORDINATOR DETAILS** | | | | | | | |
| Name: | Phone: | | | | Email: | | |
| **PLAN DETAILS** | | | | | | | |
| Hours available for service: | | | Funding available for service: | | | | |
| Please attach the NDIS plan | | | | | | | |
| NDIS number: | | | | Plan period: | | | |
| **SERVICE** | | | | | | | |
| Service(s) requested: | | | | Podiatry  Physiotherapy  Occupational Therapy  Speech Therapy  Behaviour support | | | |
| Reason for referral: | | | |  | | | |
| Relevant medical history and primary Diagnosis: (if possible, attach GP Health Summary) | | | | Brief details | | | |
| Is current (within 4 weeks) medications list attached? | | | | Yes  No Details: | | | |
| Any additional relevant information: | | | |  | | | |
| Other services currently involved (please include contact details) | | | |  | | | |
| **CONSENT** | | | | | | | |
| Did the service recipient (consumer) provide consent for the referral?    If the consumer is unable to provide consent, please clarify the reasons: | | | | Yes  No  Verbal  Written  Details: | | | |
| If the consumer is unable to provide consent, has consent for referral been obtained by Primary Guardian, NDIS Plan Nominee or Child Representative?  Please provide details of the consent provider: | | | | Yes  No  Name:  Address:  Contact:  Certified plan nominee status (please attach evidence):  Relationship to service user: | | | |
| For Primary Guardians with a power of attorney only;  As the primary guardian do you have consent to make personal, medical and lifestyle choices for the consumer using a power of attorney? | | | | Yes  No  N/A | | | |
| Did the consumer or nominated representative consent as part of this service to provide training and support to any implementing service providers? | | | | Yes  No  N/A | | | |
| **REFERRER DETAILS** | | | | | | | |
| Name: | | | | Phone: | | | Email: |