

## NDIS group support application and referral form

### Source of referral:

|                |        |
|----------------|--------|
| Name:          | Phone: |
| Agency:        |        |
| Email address: |        |

### Does the participants have a case manager at the Local Health District Service?

|     |    |
|-----|----|
| Yes | No |
|-----|----|

|  |       |    |
|--|-------|----|
| Name:  | Team: |    |
| Contact number:                                    |       |    |
| Email address:                                     |       |    |
| Is the participant willing to engage with Uniting? | Yes   | No |

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## Participant details:

|   |                     |
|---|---------------------|
| Last name:  | First name/s:       |
| Address:  | Postcode:           |
| Telephone:  | Mobile:             |
| Date of birth:  | Gender:             |
| Country of birth:                                     | Sexual orientation: |
| CALD / ATSI:  | Employed: Yes No    |
| Languages spoken:                                     | Pension: Yes No     |
| Interpreter/cultural liaison officer required: Yes No | Employment type:    |
|   | Pension type:       |

## NDIS:

|                           |     |    |
|---------------------------|-----|----|
| Do you have an NDIS plan? | Yes | No |
|---------------------------|-----|----|

If Yes, please provide the following details.

|  |                   |    |
|--|-------------------|----|
| NDIS number:   |                   |    |
| Start date of plan:  | End date of plan: |    |
| Is your NDIS plan managed by someone else?                   | Yes               | No |
| Registered Plan Management Provider details (if applicable): |                   |    |
| Name:  | ABN:              |    |
| Address:   |                   |    |
| Phone:   |                   |    |

|  |
|--|
| If successful in accessing this service, is funding included in your plan? |
|--|

## NDIS continued:

What are your NDIS goals as per your plan?

1.

2.

3.

4.

5.

Are you aware of who your Local Area Coordinator is?

How many days a week and what activities would you like to do with our program?

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## Support details:

Does the participant have a nominated carer?

Yes

No

Relationship to participant:

## Next of kin details:

Name:

Phone number:

Relationship:

Does the participant have pets?

Yes

No

If Yes, what kind:

Does the participant have children?

Yes

No

If Yes, do they live with you?

Yes

No

Ages:

## Support details continued:

### GP:

Name of person:

Phone number:

Name of organisation:

Address:

### Psychiatrist:

Name of person:

Phone number:

Name of organisation:

Address:

### Psychologist:

Name of person:

Phone number:

Name of organisation:

Address:

### Social worker:

Name of person:

Phone number:

Name of organisation:

Address:

### Other health provider:

Name of person:

Phone number:

Name of organisation:

Address:

### Other agencies currently involved, including service they provide:

## Health and functional information:

Does the participant have a diagnosed mental illness?

Yes

No

### Primary diagnosis

Schizophrenia

Eating disorder

Bipolar disorder

Post-natal depression

Depression

Schizo-affective

Anxiety

Other diagnosis:

Personality disorder

Not known

### Secondary diagnosis:

### Allergies:

### Other medical conditions:

### Current medications:

### Brief history:

## Health and functional information continued:

|   |     |    |
|---|-----|----|
| Financial management issues:  | Yes | No |
| Behaviour concerns:   | Yes | No |
| Forensic history:   | Yes | No |
| CTO in place:   | Yes | No |
| Substance abuse:  | Yes | No |
| Self-harm:  | Yes | No |
| Suicide attempts:   | Yes | No |
| Current suicide ideation:   | Yes | No |
| Violence and aggression:  | Yes | No |
| Risk-taking behaviours  | Yes | No |
| Are there any risks we should be aware of when working with this person, current or historical? | Yes | No |
| Please detail:  |     |    |

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE ATTACH ALL RELEVANT INFORMATION TO REFERRAL FORM**

## Supporting information attached

Please attach a current copy of the medication regime, and a history of psychiatric admissions.

|           |     |    |
|-----------|-----|----|
| Attached: | Yes | No |
|-----------|-----|----|

Please ensure recently completed, relevant, standardised assessment tools, measurement tools and discharge summaries are attached at the time of referral.

|  |     |    |
|--|-----|----|
| Has the participant been involved in completing this form? | Yes | No |
|--|-----|----|

\* The Privacy Act requires the participant to sign this form giving their consent for the release of their information and details.

\* Current risk assessment must be provided

**(If there is no current risk assessment, please contact Uniting)**

**CONSENT:**

I give my consent to the Uniting to seek/share information with the following people concerning matters related to this application:

Local Health District

Medical service / Health professionals

Housing provider

Other non-government organisations

De-identified statistics for program evaluation

NDIS / NDIA including Local Area Coordinator

Other:

I also give my consent to Uniting to keep a record of my referral. I understand that this information will be coded to protect my identity and will only be accessible to the services that I come into contact with.

I agree to allow Uniting staff to call me (or my designated contact person if I am not contactable) in order to update my information and to see if I am still interested in Uniting.

Signed:

Print name:

Date:

The referrer agrees that all information submitted in this referral is an accurate reflection of the client's support needs, is correct with no information withheld, and is necessary for Uniting to fulfil its duty of care to clients, employees and other partner agencies.

REFERRER'S NAME (PRINT):

DESIGNATION:

REFERRER'S SIGNATURE:

DATE:

