**CLIENT REFERRAL FORM – SECTION A**

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| **Referred by**  |
| Name: Enter text. | Organisation: Enter text. | Contact number: Enter text. |
| Relationship to client: Enter text. | Email address: Enter text. |
| Services requested: | [ ] Support Coordination/ Case Management[ ] Plan Management Please complete Section A. | [ ] Attendant Care.[ ] Accommodation. [ ] Other: Please complete both Section A & B.  |
| Client Details |
| Name: Enter text. | Primary Contact Number: Enter text. |
| Date of Birth: Enter text. | Secondary Contact Number: Enter text. |
| Gender: Enter text. | Current Address: Enter text. |
| Email Address:  |  |
| Primary Disability:  Enter text. | Secondary Disability: Enter text. | Additional Information (including health alerts e.g., asthma, epilepsy) Enter text. |
| Are there any cultural or religious needs? Enter text. |
| If an interpreter is required, specify what language: Enter text. |

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| **Nominated Person Details**  |
| **Primary Contact** | **Next of Kin (if different to Primary Contact)** |
| **Name:** Enter text. | **Name:** Enter text. |
| **Relationship:** Enter text. | **Relationship:** Enter text. |
| **Address:** Enter text. | **Address:** Enter text. |
| **Telephone:** Enter text. | **Telephone:** Enter text. |
| **Email Address:** Enter text. | **Email Address:** Enter text. |
| **Current Services (E.g., Support Coordinator, General Practitioner, Occupational Therapist)**  |
| Service/ Agency | Contact Name | Contact Number | Support Provided |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. | Enter text. |
| **Additional Information** |
| If meeting is being conducted at the client’s residence, please detail any risks we should be aware of:Enter text. |
| NDIS / TAC Number (if applicable): Enter text. | NDIS Plan Start Date: Enter text. |
| NDIS Plan End Date: Enter text. |
| **Please attach any supporting documents (e.g., NDIS Plans, medical plans, specialists reports) to** **support@dss.com.au****.** |

**CLIENT REFERRAL FORM – SECTION B**

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| **Support Information** |
| **Mobility/ Motor Skills**E.g., moving about the house, getting in and out of bed, leaving the house, moving around the community.  | Does the client require mobility assistance?[ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| **Communication**E.g., able to be understood as well as having the ability to understand and express needs and wants using age-appropriate speech and gestures.  | Does the client require communication assistance?[ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| **Social Interaction**E.g., making and keeping friends, interacting with the community, coping with feelings and emotions.  | Does the client require assistance to be social?[ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| **Learning**E.g., understanding and remembering information, learning new things and use new skills.  | Does the client require assistance to learn?[ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| **Self-management**E.g., doing daily jobs, making decisions and handling problems and money.  | Does the client require assistance with self-management activities?[ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |

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| **Personal Care** |
| Does the client require help with:  |
| Eating/ Drinking | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Showering | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Shaving/ grooming | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Dressing | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Dental hygiene | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Toileting | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |
| Foot care/ Nail care | [ ]  No[ ]  YesIf assistance is required, please provide details: Enter text.  |

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| **Challenging Behaviours** |
| **Behaviours** | **Present** | **Examples (including risks to self or others)**  | **Triggers** | **Behaviour strategies** |
| Verbal aggression | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Physical aggression | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Socially inappropriate behaviour | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Sexually appropriate behaviour | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Impulsivity | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Wandering | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Self-harm | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Drug/ Alcohol | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |
| Other | [ ]  Yes | [ ]  No | Enter text. | Enter text. | Enter text. |