Far North Community Services – Core Supports

Referral Form

Purpose: *This form is to be filled out by the Referrer whenever a new client is referred or new plan of an existing client is obtained and sent to the Far North Community Services Disability Services Manager.*

Participant Details			
First Name:		**Surname:**	
Date of Birth:	Click or tap to enter a date.	**Preferred Name:**	
Address:			
Postal Address:			
Phone No.		**Email:**	
Gender:	☐ Female ☐ Male ☐ Other:		
Cultural Identity:	☐ Aboriginal ☐ Torres Strait Islander ☐ CALD ☐ Neither		
Language Group:			
Main Language Spoken at home?		**Need an Interpreter?**	☐ No ☐ Yes
Preferred Method of Contact?	☐ In Person ☐ Phone ☐ SMS ☐ Email ☐ Post ☐ Client Portal ☐ via Support Coordinator ☐ via Support Person		

Support Person 1 Details *Complete if applicable:*			
Name:			
Relationship to Participant:			
Phone:		Email:	
Support Person 2 Details *Complete if applicable:*			
Name:			
Relationship to Participant:			
Phone:		Email:	

Participant Information	
Background Information About You Please provide a brief description of: • likes • dislikes • living arrangements • family • friends and informal support network • things that are important to you	

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NDIS Details					
NDIS Ref#:					
Plan Start Date:	Click or tap to enter a date.	Plan End Date:	Click or tap to enter a date.	Plan Review Date:	Click or tap to enter a date.
Pricing Category:	☐ National	☐ Remote	☐ Very Remote		
Management type:	☐ Agency	☐ Plan	☐ Self		
Primary Disability:					
Secondary Disability:					

Core Supports Request Details		
Service		**Funding Allocation ($)**
Daily Activities	☐ Personal Care	
	☐ Cooking	
	☐ Household Care	
	☐ Yard Maintenance	
Community Participation	☐ Community Access	
	☐ Community Programs	
	☐ Transportation	
Accommodation Services	☐ Supported independent Living	
	☐ Short Term Accommodation / Respite ***– please complete our STA Referral Form instead***	
Other	☐ Consumables	
	☐	

Support Coordinator Details *Complete if applicable:*			
Name:			
Organisation:			
Phone:		Email:	

Plan Manager Details *Complete if applicable:*			
Name:			
Organisation:			
Phone:		Email:	

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far north community services

Please tell us what supports are you seeking and the days and times if you already know this. ☐ Not Sure						
☐ SUN	☐ MON	☐ TUES	☐ WED	☐ THU	☐ FRI	☐ SAT
☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight	☐ AM ☐ PM ☐ Overnight
☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:	☐ Daily Activities ☐ Community Participation ☐ Other:

Any Staffing Preferences? (e.g. male, female, age, specific cultural background)	

Questionnaire	
Living Arrangements?	☐ Live with family ☐ Live with friends ☐ Live Alone →Do you have contact with others? ☐ Yes ☐ No ☐ unsure Frequency:
Communication Requirements?	☐ Not Required ☐ Verbal (with assistance) ☐ Non-Verbal ☐ Low tech AAC e.g signs, written, visual aids, PODD Book ☐ High tech AAC e.g talking/communication device ☐ Additional languages: _____
Current use of Assistive Technology and Mobility Aids?	☐ Not Required ☐ Mobility Aids required but not yet obtained ☐ Walking aids ☐ Wheelchair (powered or manual) ☐ Hoist, commode or high/low bed ☐ Physical support from another person
Any Fears or Phobias?	☐ Yes ☐ No ☐ unsure If yes, please describe:
Any known Allergies?	☐ Yes ☐ No ☐ unsure If yes, please describe:
Are basic needs being met including food security?	☐ Yes ☐ No ☐ unsure
Does participant have Behaviours of Concern?	☐ Yes ☐ No ☐ unsure

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Does participant have a current Positive Behaviour Support Plan (PBSP)?	☐ No → Is a PBSP required? ☐ Yes ☐ No ☐ unsure ☐ Yes → Dated: Click or tap to enter a date.
Is there a history of Alcohol or Substance Abuse?	☐ Yes ☐ No ☐ unsure If yes, please describe type e.g Cannabis, Alcohol, Amphetamines:
Is there a history of abuse?	☐ Yes ☐ No ☐ unsure If yes, please describe:
Any previous or current mental health conditions?	☐ Yes ☐ No ☐ unsure If yes, please describe:
List frequency of contact with immediate family & method of contact (e.g. face to face or phone)	☐ Frequent ☐ Regular ☐ Irregular ☐ Seldom
List frequency of contact with extended family & method of contact (e.g. face to face or phone)	☒ Frequent ☐ Regular ☐ Irregular ☐ Seldom
List frequency of contact with friends & method of contact (e.g. face to face or phone)	☐ Frequent ☐ Regular ☐ Irregular ☐ Seldom
Are there safety hazards for staff visiting the family home or accommodation? (E.g. dogs)	☐ Yes ☐ No ☐ unsure If yes, please describe:
Are there any risks associated with contact with family, friends or community members?	☐ Yes ☐ No ☐ unsure If yes, please describe:
Are there any additional Risks to be aware of?	☐ Yes ☐ No ☐ unsure If yes, please describe:

☐ Provided copy of the NDIS Plan
☐ Documented / Signed NDIS Third Party Consent to Share Form for Far North Community Services

Referrer Details:			
Name:			
Email:			
Signature:		Date:	Click or tap to enter a date.

Please email completed referral form to:

Derby / Fitzroy Valley Region rosalind.clarke@farnoth.org.au

Broome Region edwink@farnoth.org.au

East Kimberley Region angelyn@farnoth.org.au