Far North Community Services – Core Supports

Referral Form

Purpose: *Core supports are essentially products or services designed to help you carry out daily tasks that will enable you to live as independently as possible and be an active participant in your community. This form is to be filled out by the Referrer for Core Support assistance from Far North Community Services and sent to our Disability Services Manager for review and development of service.*

Your (Participant) Details			
First Name:		**Surname:**	
Date of Birth:	___/___/_____	**Preferred Name:**	
Address:			
Postal Address:			
Phone No.		**Email:**	

Primary Support Person 1 Details			
Name:			
Phone:		Email:	
Relationship to you:			

Primary Support Person 2 Details			
Name:			
Phone:		Email:	
Relationship to you:			

NDIS Details			
NDIS Ref#:			
Plan Start Date:	___/___/_____	Plan End Date:	___/___/_____
Pricing Category:	☐ National	☐ Remote	☐ Very Remote
Management type:	☐ Agency	☐ Plan	☐ Self
Primary Disability:			
Secondary Disability:			

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

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

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Background Information	
Please provide a brief description of: • likes • dislikes • activities you enjoy doing • your living arrangements • family • friends and community network • things that are important to you • cultural connections • work opportunities	

Gender:	☐ Female ☐ Male ☐ Other:		
Cultural Identity:	☐ Aboriginal ☐ Torres Strait Islander ☐ CALD ☐ Other:		
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 Primary Support Person/s		

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Core Supports Request Details		
Service		**Funding Allocation ($)**
Daily Activities	☐ Personal Activities	
	☐ Household Tasks	
	☐ Development - life skills	
Social & Community Participation	☐ Community Access	
	☐ Community Programs / Daytime Activities	
	☐ Transportation	
Accommodation Services	☐ Supported independent Living	
	☐ Individualised Living Options	
	☐ Short Term Accommodation / Respite	
Other	☐ Consumables	
	☐	
Total Funding Allocation ($)		

Please tell us what specific supports you are seeking and the days / times	☐ Not Sure

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

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Questionnaire	
Living Arrangements?	☐ Live with family ☐ Live with host ☐ Live with friends / housemates ☐ Live Alone →Do you have contact with others? ☐ Yes ☐ No ☐ unsure Frequency:
Communication Requirements?	☐ Not Required ☐ Speaking (with assistance) ☐ Non-Speaking ☐ 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
Care Requirements? (please attach supporting documentation)	☐ Not Required ☐ Mealtime Management ☐ Personal Care – Showering / Toileting / Dressing ☐ Enteral Feeding ☐ Stoma Care ☐ Complex Bowel Care ☐ Tracheostomy Care ☐ Continence Support ☐ Urinary Catheter Care ☐ Ventilation ☐ Subcutaneous Injection ☐ Diabetes ☐ Epilepsy / Risk of Seizure ☐ Pressure Care / Wound Management ☐ Awake Night Support ☐ Medication Administration ☐ Other:
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
Does participant have a current Positive Behaviour Support Plan (PBSP)?	☐ No → Is a PBSP required? ☐ Yes ☐ No ☐ unsure ☐ Yes → Dated: ____/____/_____ (please attach a copy of PBSP to the referral)

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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:	___/_____/_____

Please email completed referral form to either:

Derby / Fitzroy Valley Region - *rosalind.clarke@farnorth.org.au*

Broome Region - *edwin.kosgey@farnorth.org.au*

East Kimberley Region – *angelyn.zulu@farnorth.org.au*

Cc: – admin@farnorth.org.au