**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**](mailto: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  Yes  If 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  Yes  If 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  Yes  If 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  Yes  If 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  Yes  If assistance is required, please provide details:  Enter text. |

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