|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **About the NDIS Participant** | | | | | | | | | | | | | | |
| NDIS Number |  | | | | | | Request Date | | |  | | | | |
| Pronouns | ☐ She/Her | | ☐ He/Him | | | | ☐ They/Them | | | ☐ Other | | | | ☐ Prefer not to say |
| Gender | ☐ Male | | ☐ Female | | | | ☐ Non-Binary | | | ☐ Transgender | | | | ☐ Other |
| First Name |  | | | | | | Surname | | |  | | | | |
| Telephone |  | | | | | | Mobile | | |  | | | | |
| Email |  | | | | | | Date of Birth | | |  | | | | |
| Address |  | | | | | | | | | | | | | |
| **Disability Information** | ☐ Psychosocial  ☐ Autism | | | | | | ☐ Intellectual  ☐ Physical | | | ☐ Mental Health  ☐ Other – Specify Below | | | | |
|  | | | | | | | | | | | | | |
| **Indigenous Status** | ☐ Aboriginal | | | | ☐ Torres Strait Islander | | | | ☐ Both | | | | | ☐ Neither |
| **Interpreter Required** | ☐ Yes | | | ☐ No | | | Preferred Language | | | |  | | | |
| **Cultural Considerations** |  | | | | | | | | | | | | | |
| **Participant’s Nominee Contact (Next of Kin)** | | | | | | | | | | | | | | |
| Name |  | | | | | | Relationship to Participant | | |  | | | | |
| Address |  | | | | | | | | | | | | | |
| Telephone |  | | | | | | Mobile | | |  | | | | |
| Email |  | | | | | | Alternative Contact | | |  | | | | |
| **About the NDIS Plan** | | | | | | | | | | | | | | |
| Start Date |  | | | | | | End Date | | |  | | | | |
| Plan Included | ☐ Yes | | | | | | ☐ No (Please specify goals if not plan provided | | | | | | | |
|  | | | | | | | |
| Billing Details | ☐ NDIA | | | | | | ☐ Third Party | | | | | | ☐ Self-Managed | |
| Hours of SC funded in current plan | | | | | |  | | | | | | | | |
| Plan Manager or Self-Management Details  (Name, Contact, Email) |  | | | | | | | | | | | | | |
| **Who is Completing this Request for Services** | | | | | | | | | | | | | | |
| Agency Name |  | | | | | | | | | | | | | |
| Contact Person |  | | | | | | Contact No. | | |  | | | | |
| Email |  | | | | | | Mobile | | |  | | | | |
| I have obtained consent from the Participant to make this referral. | | | | | | | | ☐ | | | | | | |
| **Reason for Referral** | | | | | | | | | | | | | | |
| Level 1 Support Coordination | | ☐ | | | | | | | | | | | | |
| Level 2 Support Coordination | | ☐ | | | | | | | | | | | | |
| Reason for referral | |  | | | | | | | | | | | | |
| Are you changing providers during your current plan? | | | | | | ☐ Yes | | | | | | ☐ No | | |
| If yes, please provide details of current service provider | | | | | |  | | | | | | | | |