Community Living Options
GREAT OPPORTUNITIES - GREAT LIFE

New Referral information

Referrer name:

Participant name:

Date of birth:

Gender: Male ◯ Female ◯

NDIS Number:

Service Delivery requested:

The following questions help us to develop your supports with you:

Summary of supports being requested e.g. in home support, Supported Independent Living, Positive Behaviour Support, Support Coordination, Specialist Support Coordination:

Does the participant have NDIS plan/funding? Yes ◯ No ◯

Please select from:

☐ SIL ☐ CORE ☐ CAPACITY BUILDING ☐ NOT SURE

Services being requested/ hours per day/week:

Do you attend regular day activities such as work, day options, community participation, school?

Yes ◯ No ◯

If yes, how many days/hours week:

What is your Diagnosis?

☐ Intellectual disability ☐ Physical disability ☐ Autism ☐ ABI ☐ Psychosocial ☐ Other

Is there a current Positive Behaviour Support Plan in place? Yes ◯ No ◯

Are there any Restrictive Practices in place? Yes ◯ No ◯

If so are they:

☐ Environmental
☐ Chemical
☐ Mechanical
☐ Unknown

How would you/the participant like us to communicate:

- ☐ Verbal
- ☐ Non verbal
- ☐ Sign language
- ☐ Other

Medical History/Diagnosis that assists us in supporting you/the participant:

Will we be administering medications? Yes ◯ No ◯

Do you/does the participant use any mobility equipment or assistive technology? Yes ◯ No ◯

If yes, please specify:

Home information

Is the participant registered with Community Housing? Yes ◯ No ◯

Is the participant SDA registered? Yes ◯ No ◯

Is the participant currently living in the home? Yes ◯ No ◯

Are they looking for new accommodation? Yes ◯ No ◯

The suburb in which the support will be provided:

Who else lives in the home? (e.g. family, friends or other SIL participants)

Staffing profiles

This helps us to determine what staff you would like

Do you have a preference for your support worker?

Gender: Male ☐ Female ☐

Approximate age group:

Any cultural concerns to take into consideration:

Once completed, please email to the Service Development Coordinator: r.tharakan@clo.org.au

---

Office use:

Continue to on boarding: Yes ◯ No ◯

Department: Operations ◯ Clinical ◯

Regional Manager/Manager:

Notes: