



New Referral information

Participant name:

Contact Number:

Date of birth:

Gender:

Male

Female

Not Specified

Contact Person:

Relationship:

Contact Number:

Email:

How did you hear about us?

Service Delivery requested:

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

Summary of supports being requested e.g. in home support, Mid-range Support, Supported

Independent Living, Positive Behaviour Support, Support Coordination, Specialist Support Coordination:

Does the participant have NDIS plan/funding?

Yes

No

NDIS number:

What funding do you have in your plan?:

 SIL CORE CAPACITY BUILDING SDA NOT SURE

Other services being received:

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

Yes

No

If yes, how many days/hours week:

How many annual hours?

What is your Diagnosis?

 Intellectual disability Physical disability Autism ABI Psychosocial Other

If other, Please give a short description:

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

Physical

Seclusion

How is the participant able to communicate:

Verbal

Non verbal

Sign language

Other

Will we be administering medications?

Yes

No

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 and postcode 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

No Preference

Is there an approximate age group that you would prefer?:

Any cultural concerns to take into consideration:

Date form completed

Once completed, please email to: admin@clo.org.au

Office use:

Continue to on boarding:

Yes

No

Department:

Operations

Clinical

Regional Manager/Manager:

Notes: