BRIDGES Health & Community Care

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NDIS CLIENT REFERRAL FORM – PRIVATE & CONFIDENTIAL

Client Consent and Privacy					
All services and supports provided by Bridges Health & Community Care are voluntary. Please confirm that you have client consent for this referral by placing a tick in the box below. All information is handled in accordance with our privacy policy available at https://www.bridgeshcc.org.au/privacy-policy					
Do you have signed consent to share this information ☐ Yes ☐ No				Please attach the signed consent form.	
Person Making Referral					
Name:				Date of Referral:	
Organisation:					
Fax:		Phone:		Email:	
Signature:					
Participants Personal Details					
Name:				Date of Birth:	
Address:					
Phone Number:					
Email Address:					
Sex:	☐ Male ☐ Female				
Gender:	☐ Man or Male ☐ Woman or Female ☐ Non-binary ☐ Use a different term (please specify): _____ ☐ Prefer not to answer				
Does the person identify as Indigenous? ☐ Yes ☐ No			If yes? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both		
Country of Birth:		Preferred Language:		Translator Required:	☐ Yes ☐ No
Please provide details of how client wishes to be contacted by Bridges to arrange an appointment – you may place a √ in multiple boxes.					
☐ Phone Number:			Can we leave a message on this phone?		☐ Yes ☐ No
Most convenient time to call:			If mobile, can we send an SMS?		☐ Yes ☐ No
Primary Disability:					
Secondary Disabilities:					
NDIS					
NDIS Number:					
Plan Dates:					
Funding - tick which applies:	☐ NDIA Managed		☐ Plan Managed	☐ Self- Managed	
Plan Manager:					
Planner Details:	☐ NDIA ☐ LAC ☐ Other: _____		Name:		
Contact Details:	Phone:		Mobile		
	Email:				

Shop 4, 130 Bourbong Street, Bundaberg Central – PO Box 4, Bundaberg 4670
Phone 1300 707 655 – Fax 4151 6186 – email NDIS@bas.org.au – www.bridgeshcc.org.au
ABN 45 402 866 190 – ACN 632 275 275

Location of Services required? e.g. Bundaberg, Rockhampton, Gladstone, Fraser Coast, North Burnett, Agnes Water, Other:				
Location:				
Support Coordinator/Recovery Coach Details (if Applicable)				
Support Coordinator:	Name:		Phone Number:	
	Email:			
Recovery Coach:	Name:		Phone Number:	
	Email:			

Carer, Advocate or Next of Kin Request for Involvement in Intake				
Type:	☐ Carer	☐ Advocate	☐ Next of Kin	☐ Nominee
Name:			Phone Number:	
Address:				
Email Address:				

Involvement from Office of Public Guardian, Public Trust, Probation, Parole, Mental Health Unit			
Adult Guardian (OPG)			
Name:		Phone Number:	
Email Address:			
Public Trust Officer			
Name:		Phone Number:	
Email Address:			
Probation/Parole Details			
Name:		Phone Number:	
Email Address:			
Mental Health Case Manager			
Name:		Phone Number:	
Email Address:			

Current Service Providers	
Allied Health:	
Occupational Therapist:	
Physiotherapist:	
Other (e.g. Equine Therapy):	
Medical Supports:	
General Practitioner:	
Psychiatrist:	
Specialist:	
Other:	

Services Requested: Type, Duration and Frequency					
☐ **Psychology**	☐ Total Available Plan Hours: _____				
☐ **Occupational Therapy**	☐ Functional Capacity Assessment				
	☐ Assistive Technology Assessment				
	☐ Other Type Intervention, Therapy or Skill Development				
	☐ Total Available Occupational Therapy Hours: _____				
☐ **Recovery Coaching**	☐ Total Plan Hours: _____				
☐ **Support Coordination**	☐ Total Plan Hours: _____				
☐ **Individual Supports**	☐ Social & Community				
	☐ Daily Living Activities				
	☐ Total Available Plan Hours: _____				
☐ **Group Supports**	Ratios:	☐ 1:2	☐ 1:3	☐ 1:4	☐ Other: _____

Additional Information Bridges Health & Community Care Ltd should be aware of about the person requiring support: Example: Risk factors, restrictive practice, current Personalised Behavioural Support Plan

How soon do you require contact from Bridges NDIS services?	
☐ Standard (within 7 working days)	☐ Urgent (within 48 hours)

If urgent intake and assessment is required, please explain why:
ONCE COMPLETED, PLEASE **EMAIL TO NDIS@bas.org.au**