

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 <input type="checkbox"/> Yes <input type="checkbox"/> No			Please attach the signed consent form.		
Personal Making Referral					
Name:				Date of Referral:	
Organisation:					
Fax:		Phone:		Email:	
Signature:					
Participants Personal Details					
Name:				Date of Birth:	
Address:					
Phone Number:					
Email Address:					
Sex:		<input type="checkbox"/> Male <input type="checkbox"/> Female			
Gender:		<input type="checkbox"/> Man or Male <input type="checkbox"/> Woman or Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Use a different term (please specify): _____ <input type="checkbox"/> Prefer not to answer			
Does the person identify as Indigenous?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both	
Country of Birth:		Preferred Language:		Translator Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide details of how client wishes to be contacted by Bridges to arrange an appointment – you may place a ✓ in multiple boxes.					
<input type="checkbox"/> Phone Number:				Can we leave a message on this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Most convenient time to call:				If mobile, can we send an SMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Disability:					
Secondary Disabilities:					
NDIS					
NDIS Number:					
Plan Dates:					
Funding - tick which applies:		<input type="checkbox"/> NDIA Managed		<input type="checkbox"/> Plan Managed <input type="checkbox"/> Self- Managed	
Plan Manager:					
Planner Details:		<input type="checkbox"/> NDIA <input type="checkbox"/> LAC <input type="checkbox"/> 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:	<input type="checkbox"/> Carer	<input type="checkbox"/> Advocate	<input type="checkbox"/> Next of Kin	<input type="checkbox"/> 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:	

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Services Requested: Type, Duration and Frequency					
<input type="checkbox"/> Psychology	<input type="checkbox"/> Total Available Plan Hours: _____				
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Functional Capacity Assessment				
	<input type="checkbox"/> Assistive Technology Assessment				
	<input type="checkbox"/> Other Type Intervention, Therapy or Skill Development				
	<input type="checkbox"/> Total Available Occupational Therapy Hours: _____				
<input type="checkbox"/> Recovery Coaching	<input type="checkbox"/> Total Plan Hours: _____				
<input type="checkbox"/> Support Coordination	<input type="checkbox"/> Total Plan Hours: _____				
<input type="checkbox"/> Individual Supports	<input type="checkbox"/> Social & Community				
	<input type="checkbox"/> Daily Living Activities				
	<input type="checkbox"/> Total Available Plan Hours: _____				
<input type="checkbox"/> Group Supports	Ratios:	<input type="checkbox"/> 1:2	<input type="checkbox"/> 1:3	<input type="checkbox"/> 1:4	<input type="checkbox"/> 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?	
<input type="checkbox"/> Standard (within 7 working days)	<input type="checkbox"/> Urgent (within 48 hours)
If urgent intake and assessment is required, please explain why:	
ONCE COMPLETED, PLEASE EMAIL TO NDIS@bas.org.au	

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