BRIDGES Health & Community Care

SUBMIT by email

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.

Personal Making Referral

Name:				Date of Referral:	
Organisation:					
Fax:		Phone:		Email:	
Signature:					

Participant's 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:			

Location of Services required? e.g. Bundaberg, Rockhampton, Fraser Coast, 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		
☐ **Recovery Coaching**	☐ Total Plan Hours: _____	
☐ **Support Coordination**	☐ Level 1: Support Connection	Total Plan Hours:
	☐ Level 2: Coordination of Supports	Total Plan Hours:
	☐ Level 3: Specialist Support Coordination	Total Plan Hours:
☐ **Group Program**		

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@bridgeshcc.org.au**

SUBMIT by email