Individualised Services referral form.

Date:	
This is a:	☐ New enquiry ☐ Enquiry for an existing participant
Is the applicant aware of the referral?	☐ Yes ☐ No
Funding type	☐ NDIS ☐ Other _____
Funding plan attached	☐ Yes ☐ No

Participant details

First name	**Last name**		
Preferred name			
Gender (include preferred pronouns if applicable)			
Address			
Suburb	**Postcode**		
Email			
Phone			
Country of Birth			
Aboriginal	☐ Yes ☐ No	**Torres Strait Islander**	☒ Yes ☐ No
Main Language spoken		**Interpreter Required**	☐ Yes ☐ No
Preferred contact method (including how & when e.g. phone call, SMS, email, days/times)			

Preferred contact person if not (or in addition to) the participant		
Name	**Relationship**	**Contact Details**

Decision making support

Legal Guardianship Order	☒ No ☐ Yes (Provide details below, contact for approval prior to continuing)
Approves of UCW involvement	☐ Yes ☐ n/a

Name:		**Contact Information:**	

Consent provided:	☐ No ☐ Yes (signed copy attached)

Family/Friends/carer that assist in decision making with or for the participant:		
Name	**Relationship**	**Contact Details**

Referrer Details

Name		**Position**	
Organisation			
Address			
Email			
Phone			

Areas of Support

Support	Amount per week

Support required with : Mobility aid/s (eg wheelchair)	
Other aid/s	
Positive Behaviour Support Plan available	☐ Yes (copy attached) ☐ No

Are there any known risk indicators?

Environment _____ ☐ No ☐ Yes

To Self _____ ☐ No ☐ Yes

To others _____ ☐ No ☐ Yes

Does the applicant have a diagnosed mental health issue? ☐ No ☐ Yes

Details:

_____

_____

Does the applicant have any other diagnosed disabilities? ☐ No ☐ Yes

Details: _____

_____

Is the applicant a permanent resident or citizen of Australia? ☐ No ☐ Yes

Details: _____

_____

Is the person dependent on alcohol or other drugs? ☐ No ☐ Yes

If so, is the person willing to address this issue? ☐ No ☐ Yes

Details:

_____-

_____

Does the applicant receive support from any other services? ☐ No ☐ Yes

Details: _____

Case Manager: _____ Phone: _____

GP: _____ Phone: _____

For assessing eligibility for the program, I give consent for Uniting WA contact and liaise with persons/services that I specify on this form.

Participant name: _____

Guardian name: _____

Signature: _____

Date: _____