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| **PARTICIPANT REFERRAL FORM** |

Chrysalis Collective appreciates that everyone is unique, please help us to get to know you and your circumstances by answering the following questions.

1. **Participant Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name: |  | | Surname: |  |
| Preferred Name: |  | | | |
| Gender: |  | | DOB: |  |
| Residential Address: |  | | Postal Address:  (If different to  residential address) |  |
| Phone: |  | | Mobile: |  |
| Email: |  | | Language: |  |
| Cultural / Religious Requirements: |  | | Interpreter Required: |  |
| Do you identify as: | Aboriginal |  | Torres Strait Islander: |  |
| Both |  | No /  Prefer not to say: |  |
| NDIS No: |  | | Plan Dates: |  |
| Preferred method of communication: | Telephone |  | SMS |  |
| Email |  | Letter |  |
| Living Situation: | Own Home (Alone)  Own Home (Family / Shared) |  | Private Rental (Alone)  Private Rental  (Family / Shared) |  |
| SIL |  | Public / Community Housing |  |
| Temporary |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. **Plan Nominee / Child Representative Details:**

Do you have a NDIS appointed Plan Nominee or Child Representative?

If yes, please complete below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name: |  | | Surname: |  |
| Preferred Name: |  | | | |
| Gender: |  | | DOB: |  |
| Residential Address: |  | | Postal Address:  (If different to residential address) |  |
| Phone: |  | | Mobile: |  |
| Email: |  | | Language: |  |
| Cultural / Religious Requirements: |  | | Interpreter Required: |  |
| Do you identify as: | Aboriginal |  | Torres Strait Islander: |  |
| Both |  | No /  Prefer not to say: |  |
| Preferred method of communication | Telephone | | Email | Letter |
| Relationship to the Participant: |  | | | |

1. **Participant Representative / Alternative Contact:**

When not a NDIS appointed Plan Nominee or Child Representative, please complete below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name: |  | | Surname: |  |
| Preferred Name: |  | | | |
| Gender: |  | | DOB: |  |
| Residential Address: |  | | Postal Address:  (If different to residential address) |  |
| Phone: |  | | Mobile: |  |
| Email: |  | | Language: |  |
| Cultural / Religious Requirements: |  | | Interpreter Required: |  |
| Do you identify as: | Aboriginal |  | Torres Strait Islander: |  |
| Both |  | No /  Prefer not to say: |  |
| Preferred method of communication | Telephone | | Email | Letter |
| Relationship to the Participant: |  | | | |

1. **Guardianship / Financial Administrator:**

Is there a Guardian and/or a Financial Administrator in place:  Yes  No

***If yes, please send us a copy of your current QCAT Order / Power of Attorney (POA) / Enduring Power of Attorney (EPOA).***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Guardian / Financial Administrator’s Name: |  | | | | |
| Address: |  | | | | |
| Phone: |  | Mobile: | |  | |
| Email: |  | | | | |
| Capacity: | QCAT Order: | | POA: | | EPOA: |

1. **Disability / Medical Conditions:**

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| --- |
| Primary Disability (Recognised by NDIS): |
| Secondary Disability (Recognised by NDIS): |
| Other Disabilities: |
| Other Medical Conditions: |
| Current Medications / Dosage: |

1. **Treatment Authority, Forensic Order or Probation Order:**

|  |  |  |
| --- | --- | --- |
| Is there a Treatment Authority in place? | Yes | No |
| Is there a Forensic Order in place? | Yes | No |
| Is there a Probation Order in place? | Yes | No |

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| Details: |
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1. **Behaviour Support:**

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| --- | --- | --- |
| Is there a Positive Behaviour Support Plan in place? | Yes | No |
| ***If yes, please provide us with a copy of the Positive Behaviour Support Plan.*** | | |

1. **NDIS Support Coordination funding is:**

|  |  |
| --- | --- |
| NDIA-Managed: |  |
| Plan-Managed: |  |
| Self-Managed: |  |
| Current balance of Support Coordination funding: | $ |
| Date balance reported: |  |

***Please provide us with a copy of your NDIS plan.***

**Please provide details of where to send our invoices:**

|  |  |
| --- | --- |
| Contact Name: |  |
| Company Name: |  |
| Address: |  |
| Telephone: |  |
| Email: |  |

1. **Existing Support Coordinator:**

|  |  |  |
| --- | --- | --- |
| Do you have an existing Support Coordinator? | Yes | No |
| If yes, how much notice are you required to give them?  *(i.e. days or weeks)* |  | |
| If you are required to give notice, have you done so already?  *If no, please have a conversation with our team before doing so.* | Yes | No |

1. **NDIS Goals:**

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1. **Risk Assessment Questionnaire:**

All referrals are subject to review and acceptance by our Directors. The below risk assessment assists our Directors to ensure a participant is appropriately matched and safety measures are put in place to mitigate any identified risks.

|  |  |  |
| --- | --- | --- |
| Questions | | |
| Is the participant aware of the referral and the purpose of our role? | Yes | No |
| Will any other person/s be present onsite during home visit/s? | Yes | No |
| If yes, please provide a description of who and their relationship to the participant: | | |
| Are there any pets in the home environment? | Yes | No |
| If yes, please provide a description of the pet/s and detail any concerns regarding risk/behaviour: | | |
| Are there any ongoing concerns with mobile reception at the address of the proposed home visit? | Yes | No |
| Are there any environmental hazards? | Yes | No |
| If yes, please provide a description of the hazards: | | |
| Does the participant have a history of physical or verbal aggression or violence against others or objects? | Yes – Current  Yes – Historic | No |
| If yes, please provide a description of these incidents: | | |
| Does the participant have a history of alcohol/drug abuse? | Yes – Current  Yes – Historic | No |
| If yes, please provide a history of misuse: | | |
| Does the participant have a risk of inappropriate or sexualised behaviours? | Yes – Current  Yes – Historic | No |
| If yes, please provide a description of these incidents: | | |

I understand that:

* This organisation owns these records.
* Information within these records will be shared with other staff within the organisation only when staff require this information to carry out their duties.
* I can ask to see records and receive a copy.
* Records are archived for a set period according to policy and procedure.
* I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

|  |  |
| --- | --- |
| Participant’s  or  Participant Representative’s  Signature: |  |
| Name of Person Signing: |  |
| Relationship to the Participant: |  |
| Date: |  |
| If verbally agreed, date and time of conversation: |  |

Please complete, sign and return this Participant Referral Form to [hello@chrysaliscollective.au](mailto:hello@chrysaliscollective.au).

***Please note an Authority to Act as an Advocate form is required if the participant’s representative is not the NDIS appointed Plan Nominee or Child Representative.***