Chrysalis Collective
TRANSFORM, EMERGE, SOAR.

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)	☐	Private Rental (Alone)	☐
	Own Home (Family / Shared)	☐	Private Rental (Family / Shared)	☐
	Supported Independent Living (SIL)	☐	Public / Community Housing	☐
	Caravan / Cabin	☐	Temporary / Emergency Accommodation	☐
	Homeless	☐	Other: _____	☐

2. 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:	☐ Yes ☐ No
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:				

3. 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:	☐ Yes ☐ No
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:				

4. 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: ☐

5. Disability / Medical Conditions:

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

6. 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

Details:

7. Behaviour Support:

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.

8. NDIS Support Coordination funding is:

NDIA-Managed:	☐
Plan-Managed:	☐
Self-Managed:	☐
Current balance of Support Coordination funding (please note we do not accept referrals for less than 48 hours/year):	$
Date balance reported:	

Please provide us with a copy of your NDIS plan. We review your plan to assess how complex your supports are and what level of support is required to implement your plan.

Please provide details of where to send our invoices:

Contact Name:	
Company Name:	
Address:	
Telephone:	
Email:	

9. 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? ☐ Yes ☐ No

If no, please have a conversation with our team before doing so.

10. NDIS Goals (if providing a copy of your NDIS plan, there is no need to complete this section)**:**

1.	
2.	
3.	
4.	
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6.	
7.	

11. 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:

- Providing false or misleading information could result in immediate termination of services.
- 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.

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.