# Behaviour Support Referral Document

## Referrer Details

|  |  |
| --- | --- |
| Name: |  |
| Relationship to you? | [ ]  Family Member [ ]  Friend [ ]  Professional [ ]  N/A |
| Phone: |  |
| Email:  |  |
| Has the client or relevant decision maker consented to this referral? | [ ]  Yes [ ]  No  |

## Client Details:

|  |  |
| --- | --- |
| Pronouns: |  |
| Name: |  |
| Date of Birth: |  |
| Address:  |  |
| Client Phone: |  |
| Client Email: |  |
| Preference for communication? | [ ]  Phone[ ]  Email[ ]  Text Message |
| Preferred language?  |  |
| Indigenous Status: | [ ]  No[ ]  Yes, Aboriginal [ ]  Yes, Torres Strait Islander [ ]  Yes, both Aboriginal and Torres Strait Islander [ ]  Prefer not to say  |
| Who are the significant people in your life?  |   |
| What level of support do you need when making decisions? | [ ]  I am fully independent with decision making [ ]  I benefit from support with complex decision making [ ]  I benefit from support with all decision making |
| Do you have an appointed Guardian? | [ ]  Yes [ ]  No If yes, please add contact details and provide a copy of any orders |

## Health information

|  |  |
| --- | --- |
| Disability / Diagnoses: |  |
| Existing Health Information:*Please list any physical health issues that you consider relevant to our working together* |  |
| Mental Health Information: *Please list any diagnosed mental health conditions* |  |
| Do you consider these diagnoses to be accurate? |  |
| Are you currently taking medication for your health?  | [ ]  Yes [ ]  No |
| General Practitioner Details:Name, Clinic Name, Phone Number |  |

## Behaviour Support

|  |  |
| --- | --- |
| Please describe any behaviours of concern we should be aware of:*E,g., Verbal Aggression, Food, Harm to Self, Sexual Behaviours (Self-Others), Physical Aggression, Withdrawal or others*  |  |
| Are there any restrictive practices in place? | [ ]  Yes [ ]  No[ ]  Unsure [ ]  Prefer not to say  |
| Please describe any involvement with the other support systems:*E.g., Mental Health, Housing, Justice and Legal, Child Protection and Family Support, Education and Employment or Other*  |  |
| What do I need to know about how you to best support you?  |  |

## Payment Information

|  |  |
| --- | --- |
| NDIS Number: |  |
| NDIS plan start date: |  |
| NDIS plan end date: |  |
| Line item available: |  |
| Total funding amount available: |  |
| How is this funding managed? | Choose an item. |
| Email address for invoices: |  |
| \*If Plan Managed: Plan Manager Name |  |
| \*If NDIA managed, have you “endorsed” us with the NDIS: | Choose an item. |

How does a participant endorse a provider? Participants endorse providers by calling the NDIS on 1800 800 110 and letting them know they want to endorse a provider in the PACE portal. They will need to give the name and NDIS Provider Number of the company they wish to endorse.

[Click Here to Download Information Guide for Participants wanting to endorse providers](https://www.myright2voice.org/_files/ugd/815069_fdc1c642586f41c4b3bc0b1b354a1412.pdf)

## Marketing and Service Delivery Feedback

|  |  |
| --- | --- |
| How can we ensure our service meets your needs? |  |
| How did you hear about us?  |  |