



## NEW REFERRAL INFORMATION

### Participant Details

Name:

Contact Number:

Date of Birth:

Gender:

### Contact

Name:

### Person Details

Relationship:

Contact Number:

Email Address:

How did you hear about us?

### Service Delivery Requested:

Summary of supports being requested e.g. Low/Mid-range Support (in home support), Supported Independent Living (SIL), Independent Living Options (ILO) Community Participation (CP).

Does the participant have NDIS plan/funding YES NO

NDIS Number:  NDIS Plan Dates:

What funding do you have in your plan?

SIL ADL CAPACITY BUILDING SDA NOT SURE

### Other Services

Do you attend regular day activities such as work,  
day options, community participation, school? YES NO

If yes, how many days/hours per week:

### What is your Diagnosis

Intellectual Disability Physical Disability Autism ABI Psychosocial Other

If other, please give a short description:

Is there a current Positive Behaviour Support Plan in place? YES NO

Are there any Restrictive Practices in place? YES NO

If yes, are they:

Environmental Chemical Mechanical Physical Seclusion



How is the participant able to communicate:

Verbal          Non-verbal          Sign Language          Other

Will we be administering medications?          YES          NO

Does the participant use any mobility equipment or assistive technology? YES          NO

If yes, please specify:

**Home Information**

Is the participant registered with Community Housing?          YES          NO

If yes, what category? (eg. Category 1)         

Is the participant SDA registered?          YES          NO

If yes, which SDA category?

BASIC          IL          FA          HPS          ROBUST

Is the participant currently living in the home?          YES          NO

Are they looking for new accommodation?          YES          NO

What suburb and postcode will the support be provided:         

Who else lives in the home? (e.g. family, friends or other SIL participants)

**Staffing profiles**

This helps us to determine what staff you would like.

Do you have a preference for your support worker?

Gender:          Male          Female          No Preference

Is there an approximate age group that you would prefer?         

Any cultural concerns to take into consideration:         

**Additional Information**

Please provide copies of any documentation that would be of assistance.

- NDIS Plan
- PBS Plan
- OT / Functional Capacity Assessment

Date form completed:          Once completed, please email to: [referral@clo.org.au](mailto:referral@clo.org.au)

Form completed by: