Referral Form
NDIS Core

Refer Details			
Name		**Organisation**	
Contact Number		**Referral Date**	
Client Details			
Name		**Contact Number**	
Address		**Date of Birth**	
NDIS Information			
NDIS Number		☐ OPG	☐ Plan Nominee
OPG/Plan Nominee Name (if applicable)		**OPG/Plan Nominee Contact Number**	
Plan Start Date		**Plan End Date**	

☐ NDIA-Managed	☐ Self-Managed	☐ Client is in PACE
☐ Plan-Managed	**Plan Manager Name**	
Client's amount of available Core funds (if known)		

NDIS Funding Disability (e.g. Schizophrenia)

Safety Information		
Is the client on a Forensic Order?	☐ Yes	☐ No
Does the client have a Positive Behaviour Support plan?	☐ Yes	☐ No

Additional Safety Information

Purpose of Support		
NDIS Goal 1	**NDIS Goal 2**	**Long Term Goal**
Support tasks to achieve Goal 1	**Support tasks to achieve Goal 2**	**Support tasks to achieve Long Term Goal**

Support Preferences							
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
No. of hours							
Preferred time (e.g. 9-12, 2-4 or afternoon)							
Activity / Task							
Preferred gender of worker		☐ Male		☐ Female		☐ No preference	
Additional preference information							