



ALLIED HEALTH REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Residential address:		Gender:	M F
Contact numbers:	H: M:		Other
Does the participant identify as:	Aboriginal	Torres Strait Islander	Neither
Cultural Background:		Language/s spoken at home:	
Interpreter Required:	Yes No		
Under the care of :	Territory Families	Public Guardian	Other _____
Name:		Email:	
Phone:		Has the referral been discussed with the participant/guardian?	Y N
Diagnosis/disability: (please attach supporting documentation)			
Does the following apply to the participant? equipment use mobility aids vision impaired hearing impaired If yes, please provide further information:			
Previous supports / Services provided: (e.g. assessments, therapy, education/school supports, work supports)			
Communication Status:	verbal	non-verbal	Auslan/Key Word Sign AAC <small>e.g. PODD, eyegaze, switches</small>
Comments: _____			

SECTION 2: THERAPY SUPPORTS REQUESTED

Speech Pathology	Occupational Therapy	Psychology	Physiotherapy	Not sure
Reason for Referral: <small>e.g. emotions, behaviours, sensory, communication</small>				

Priority Needs	Please let us know if the participant experiences any of the following:			
Swallowing difficulties (dysphagia)	Falls	Pressure Injuries	Botox	
Risk to Self	self-harm suicidal ideation risk taking behaviours accommodation break down	substance abuse unable to access community (i.e. school) absconding (i.e. running away) cognitive impairment with limited supports	Risk to Others	violent other
As a primary carer, do you feel like you are experiencing / at risk of carer burnout?			Yes	No
Comments: _____				

SECTION 3: FAMILY BACKGROUND INFORMATION (optional)

Parent/Guardian/Caregiver's Name/s:		married other	de-facto court orders	separated
Significant life events/family stressors:				
Sibling Information: (name, age, relevant developmental details, medical needs, living arrangements etc)				

SECTION 4: FUNDING

NDIS Plan approved.	Yes	Pending (waiting NDIS response)	Not commenced	Not applicable
NDIS number:		Plan start date:		Plan end date:
If not NDIS funded, what is the funding source?				
Medicare	Government	Defence	Private	Other _____
NDIS COS Details				
Name:		Organisation:		
Email:			Phone:	
Plan Management	Agency managed	Plan managed	Self-managed	
If Plan Managed, contact details of Plan Manager:				
Name:		Organisation:		
Email:			Phone:	

SECTION 5: PRIMARY CONTACT DETAILS

Participant / Parent / Guardian			
Address:		Contact numbers:	H. M.
Email:			
Signature:		Date:	

SECTION 6: SECONDARY CONTACT DETAILS

Participant / Parent / Guardian			
Address:		Contact numbers:	H. M.
Email:			
Signature:		Date:	

SECTION 7: REFERRER DETAILS

Relationship to client:	Guardian (completed above. No further details required) Coordinator of Supports (complete referrer details)		Other (complete referrer details)
Organisation (if app.):		Contact numbers:	B. M.
Name:			
Postal address:			
Email:			
Signature:		Date:	

Please tick documents that have been provided to assist in planning:

Assessment reports

NDIS Plan Goals

Copy of NDIS Plan (optional)

Please send the completed referral form to intake@carpentaria.org.au.

For additional enquiries regarding this referral, please phone the Intake Officer on 8920 9400

Completing this form is not a guarantee that the service can be provided. Carpentaria requires completion of a service agreement for all services provided

! Please ensure all sections of this form are completed in order for us to process the referral in a timely manner.