



PATHWAYS PROGRAM REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Other names: (if applicable)		Gender:	Male Female
Residential address:			
Postal address: (if different)			
Contact numbers:	Home:	Mobile:	
Does the Participant identify as:	Aboriginal	Torres Strait Islander	Neither
Has the Participant consented to this referral?	Yes	No	
Primary diagnosis / disability: (please attach supporting documentation)			
Secondary disability(ies) or other presenting issues:			
Communication status: (eg. verbal, sign etc)			
Personal mobility aids:			
Mobility aids required:	Hoisting	Commode	Sarah Steady
	Any other Assistive Devices _____		
Does Participant have challenging behaviours?			
Does participant have a current Behaviour Support Plan (PBSP)?	Yes Dated _____ (please provide a copy)	➔	Has a PBSP review been requested Yes No
	No	➔	Is a PBSP required? Yes No
Requested ratio of support:	1:1	1:2	Other

SECTION 2: PATHWAYS PROGRAM ATTENDANCE

Please provide a copy of participant's goals from their NDIS Plan prior to commencement.

Please select days to attend:			Comments/program
Monday	AM	PM	
Tuesday	AM	PM	
Wednesday	AM	PM	
Thursday	AM	PM	
Friday	AM	PM	

SECTION 3: TRANSPORT REQUIREMENTS

Please select below:

Monday		Tuesday		Wednesday		Thursday		Friday	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

SECTION 4: NDIS PLAN

NDIS Plan approved:	Yes	Pending (waiting NDIS response)	Not commenced	Not applicable
NDIS number:		Plan start date:		Plan end date:
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: CONTACT DETAILS

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

SECTION 6: REFERRER DETAILS

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

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