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| **PARTICIPANT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of NDIS Participant: | | | | | | | | |  | | | | | | | | Gender: | | |  | | | | | D.O.B: | | |  | |
| Address: |  | | | | | | | | | | | | | | | | Phone number: | | | | | |  | | | | | | |
| Email: |  | | | | | | | | | | | | | | | | Interpreter required: | | | | | | | | | Yes | | | No |
| NDIS Approved Disability: | | | | | | |  | | | | | | | | | | Language: | | |  | | | | | | | | | |
| **TELL US ABOUT THE PARTICIPANT** | | | | | | | | | | | | | | | | **NDIS GOALS:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **REFERRAL REQUIREMENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Functional Capacity Assessment | | | | | | | | | | | | Cognitive Assessment | | | | | SDA Assessment | | | | | | | Sensory Assessment | | | | | |
| Home modifications | | | | | | *(Areas):* | | | | |  | | | | | | | | | | | | | | | | | | |
| Equipment/Aids/Assistive Tech | | | | | | | | | | | *(Details):* | |  | | | | | | | | | | | | | | | | |
| Life skills training/Therapy | | | | | | | | | | *(Details i.e. cooking):* | | | |  | | | | | | | | | | | | | | | |
| Other: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLAN DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NDIS Participant Number: | | | | | | | |  | | | | | | | How is the NDIS Plan Managed:  NDIA Managed  Plan Managed  Self-Managed | | | | | | | | | | | | | | |
| NDIS Plan Dates: | | |  | | | | | | | | | | | | Invoices to: | | |  | | | | | | | | | | | |
| **PARTICIPANTS ALTERNATE CONTACT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alternative Contact: | | | | |  | | | | | | | | | | Relationship: | | | |  | | | | | | | | | | |
| Phone numbers: | | | | |  | | | | | | | | | | Email: | | | |  | | | | | | | | | | |
| Is this participant under the guardianship of the Public Guardian and Trustee? | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | | |
| Who is the most suitable person to contact to book the initial assessment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | Best Contact Number: | | | | | |  | | | | | | | | |
| **REFERRER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Referrer: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Organisation name: | | | | |  | | | | | | | | | | Role: | |  | | | | | | | | | | | | |
| Phone numbers: | | | | |  | | | | | | | | | | Email: | |  | | | | | | | | | | | | |

Please return this form to [admin@leadinghealthsolutions.com.au](mailto:admin@leadinghealthsolutions.com.au)