|  |
| --- |
| **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