**(NDIS) - ECEI REFERRAL FORM**

| **Participant Details** | |
| --- | --- |
| **First Name** |  |
| **Surname** |  |
| **Preferred Name** |  |
| **Gender** | ☐ Male ☐ Female  ☐ Do not wish to disclose  ☐ Other (provide details below):  Preferred gender:  Preferred pronoun: |
| **D.O.B** |  |
| **Living Arrangements** | ☐ Living with parents ☐ Living with grandparents  ☐ Shared care  ☐ Other alternative living arrangements (provide details   below): |
| **Home Address** |  |
| **Contact Number** |  |

| **Diagnosis/ Disability/ Condition** | Main Disability:  Other (please specify): | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Specific Medical Needs/ Conditions (i.e., allergies/ asthma)** |  | | | | | |
| **Country of Birth** | ☐ Australia ☐ Other:  ☐ Language spoken if not English: | | | | | |
| **Currently Attending** | ☐ Preschool ☐ Day program  ☐ Other: | | ☐ Mainstream   school | | ☐ Special school ☐ Child care | |
| **Communication** | ☐ Verbal  ☐ Augmentative | | | ☐ Non-Verbal  ☐ Other: | | |

| **Parent / Carer Details** | |
| --- | --- |
| **Name** |  |
| **Relationship to Participant** |  |
| **Home Address** |  |
| **Contact Number** |  |
| **Email** |  |
| **Alternate preferred contact**  **(Name, contact number, email etc.)** |  |
| **Preferred Contact Method** |  |

| **Referral Information** |
| --- |

| **Person Making the Referral** |  | | |
| --- | --- | --- | --- |
| **Contact Number** |  | **Relationship to Referred Person** |  |
| **Email** |  | | |
| **Person Responsible for Signing the Service Agreement** | ☐ Parent/Guardian  ☐ Office of Public Guardian/ Public Advocate  ☐ Support Coordinator  ☐ Other: | | |
| **Contact Details of Authorised Signatory** |  | | |
| **Is this Referral Urgent?** |  | | |
| **Risks** | ☐ Verbal Aggression ☐ Physical Aggression  ☐ Other: | | |
| **Does the Participant have a Behaviour Support Plan?** |  | | |
| **When was it Developed?** |  | | |

| **Expected Outcomes** | | |
| --- | --- | --- |
| **Expected Outcomes from Service** | ☐ Same as NDIS Goals  ☐ Other: | |
| **Expected Timeframe for Receiving Service** | ☐ As soon as possible  ☐ 2-4 weeks  ☐ 4-6 weeks  ☐ 6-8 weeks | |
| **Where is Support to be Provided (multiple locations may be selected)** | ☐ Family Home  ☐ Telehealth  ☐ Other | ☐ Child/Day Care  ☐ School |

| **NDIS Plan Details** | | | | |
| --- | --- | --- | --- | --- |
| **NDIS Number** |  | | | |
| **Plan Managed Type** | ☐ NDIA/ Agency managed  ☐ Plan Managed  ☐ Self-Managed | | | |
| **NDIS Plan Dates** | *Start:* | | *End:* | |
| **Support Categories** | ***Improved Daily Living*** | ☐Yes  ☐ No | | Amount: $ |
| ***If Applicable:*  Plan Manager and contact details** |  | | | |

| **Consent** | | | |
| --- | --- | --- | --- |
| *This information will be used to inform allocation of support and it will be stored securely by Positive Mind Body. Should you decide to not use Positive Mind Body’, your hard copy and soft information will be destroyed.*   * I understand how my child’s personal information will be collected, used and disclosed for the purposes of the NDIS. * I have carefully read all of the information provided in the information form and confirm that it is accurate, complete and up to date. * I consent to Positive Mind Bodycollecting, using and disclosing personal and sensitive information about my child. * I understand that I may withdraw consent to receive support from an ECEI service provider at any time. * I give permission to contact the professional completing / assisting with this information form. | | | |
| **Person Responsible for Signing** | ☐ Parent/ Persons  Responsible | ☐ Guardian | ☐ Other: |
| **Name** |  | | |
| **Signature** |  | | |
| **Date** |  | | |