**BEHAVIOUR SUPPORT REFERRAL FORM (NDIS)**

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| **Who is the referral for?** |

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| **Name** |  | * Male * Female * N/A | |
| **D.O.B** |  |  | |
| **Living Arrangements:** | * Living with family * On own | * Group home * Other: | |
| **Address** |  | | |
| **Phone:** |  | | |
| **NDIS Number:** |  | | * NDIA * Plan Managed |

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| **Diagnosis/Disability (including mental health diagnoses):** | Main Disability:  Other, please specify: | | |
| **Specific Medical Needs/Conditions (ie: allergies/asthma:** |  | | |
| **Country of Birth** | * Australia * Other: * Language Spoken: | | |
|  | * Identifies as Aboriginal or Torres Strait Islander * Other cultural background: | | |
| **Currently Attending:** | * Preschool * Day program | * Mainstream School * Other: | * Special School |
| **Employment:** | * Supported Employment * Open Employment | | Other: |
| **Communication:** | * Verbal * Non-Verbal | | Augmentative  Other: |

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| **Referral Information** |

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| **Person Making the Referral\*:** |  | | |
| **Contact Number:** |  | **Relationship to Referred Person** |  |
| **Email Address:** |  | | |
| **\*Who is the Person Responsible for Signing this Service Agreement:** | * Parent/Guardian * Office of Public Guardian / Public Advocate * Support Coordinator * Other | | |
| **Contact details of Authorised Signatory:** |  | | |
| **Is this Referral Urgent?** |  | | |
| **If Yes, Please Explain Why** | * Imminent risk of injury to self or others * Risk to or current loss of placement * Significant reduction in community access * Currently has restrictive practice in use that does not have written procedures or a BIS plan * Other (please give description): | | |
| **Risks** | * Verbal Aggression * Physical Aggression * Injury to self/other * Substance abuse * Police involvement | * Mental health * Transition phase * Sexualised behaviour * Other: | |
| **Does the person have a behaviour support plan?** |  | | |
| **When was it developed?** |  | | |

**Does the person have any Regulated Restrictive Practices in place?**

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| **Type of restrictive Practices** | **Y /N** | **Describe the Practice** | **Is the restricted Practice in their current behaviour support plan** | **Date of last authorisation** |
| **Seclusion** |  |  |  |  |
| **Chemical Restraint** |  |  |  |  |
| **Mechanical Restraint** |  |  |  |  |
| **Physical Restraint** |  |  |  |  |
| **Environmental restraint** |  |  | . |  |
| **Does the person have a Confirmation of Purpose of Medication Form?** |  | **If NO, details of GP or who we can contact to complete:** |  | |
| *PMB identifies participants' culture, diversity, values and beliefs and sensitively responds to their needs. We support participants' right to practice their culture, values and beliefs. Our employees support and assist a participant's decision to be involved in the community of their choice.*  **Please add any comments or information you wish to share with us here:** | | | | |
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| **Expected Outcomes** | | | | |
| **Expected Outcomes from Service:** |  | | | |
| **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 can be selected):** | * Family Home * Own Home * Telehealth | * Group Home * Day Care | * Respite/Day Program * Other | |
| **Primary Contact Person** | * Participant | * Parent/Persons Responsible | * Guardian | * Other |
| **Name:** |  | | | |
| **Phone/Email:** |  | | | |
| **Address:** |  | | | |

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| **Checklist: Documents to help provide Behaviour Support** | |
|  | Functional Assessment interview form |
|  | Health care plan |
|  | Mental health care plan |
|  | Person Centered/Lifestyle Plan |
|  | ABC Data/Incident Reports |
|  | Relevant Medical reports (Eg. GP, Paediatrician, Psychiatrist or Neurologist) |
|  | Psychology/Counsellor Reports |
|  | Medication Chart |
|  | Risk profile |
|  | Previous Behaviour Support plans and/or functional behaviour assessment (if any) |
|  | Speech pathology assessments |
|  | Occupational therapy assessments |
|  | Any existing restricted practices documentation (Eg. submission, outcome summary). |
|  | Copy of NDIS Plan \*\*We recommend that you add a copy of the plan. Having a full copy of the plan will assist in achieving the participants goals\*\* |

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| **NDIS Plan Details** | | | |
| **Plan Dates:** | *Start:* | | *End:* |
| **Support Categories:** | ***Improved Relationships:***  (Standard) | * Yes * No | Amount: $ |
| ***Improved Relationships:***  (Specialist) | * Yes * No | Amount: $ |
| ***Improved Daily Living:*** | * Yes * No | Amount: $ |
| **Is the Participant NDIA or Plan Managed?** | * NDIA * Plan Managed (If Plan Managed, please enter details below) | | |
| **If Applicable: Name & Contact Details of Plan Managers & email for invoicing.** |  | | |
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| **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.* | | | |
| **Are you:** | * The participant | * Parent/Persons Responsible | * Guardian |
| **Name:** |  | | |
| **Signature:** |  | | |
| **Date:** |  | | |