



Client Referral Form

Referral Details

Referral date*

Has the client/ person requiring services given verbal consent for referral? *

Yes No

Which services are you referring to?*

NDIS Services

- Core Support (Personal Care) Core Support (Community Access)
 Support Coordination Level II Support Coordination Level III
 Psychosocial Recovery Coaching Social Work Counselling Plan Management
 Group Based Activities - Art Programs

TAC/ WorkSafe Services

- Attendant Care Supported Independent Accommodation
 Intensive Specialist Case Management Outreach

Other Services

- Community Programs Counselling - Fee for Service Social Work - Fee for Service

Funding type*

- Agency Managed Self Managed Plan Managed Fee for Service TAC Managed
 WorkSafe Managed

NDIS number/ TAC number/ WorkSafe number*

Specify Plan Manager (if any)

Funding available*

Hours/ days requested per week (if applicable)*

Commencement date*

End/review date

NDIS plan start date

NDIS plan finish date

"High" referral urgency must include information detailing reasons

Client Details

Name (or Alias)*

Date of birth*

Gender

Phone number*

Email

Identify as part of LGBTQIA+ community

Pronouns

Identify as CALD

Address*

Suburb*

Postcode*

Does the client live alone?

Yes No

If No, please provide details

Country of birth

Nationality

Interpreter required

Yes No

ATSI

Yes No

Client's Source of Income (DSP, New Start, etc)

Financial administration

Yes No

If Yes, please detail

Name

Phone

Email

Does the client have a legal guardian

Yes No

If Yes, please detail

Legal guardian name

Legal guardian Phone

Legal guardian email

Can the client read and write?

Client's current occupation







Duration

Previous occupation details

Additional Support Details





Other formal supports

List all other linked services, including contact details:

Name	Role	Phone	Email		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Current informal supports

Please detail including contacts:

Name	Role	Phone	Email		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Emergency Contact Details

Name*

Relationship*

Address*

Phone*

Email*

Psychosocial history

Provide relevant information on clients' relationship status & family status

Recreational interests

Detail information on clients' interests/activities currently engage with

Medical Details

Please provide information on **primary** disability*

Please provide information on **secondary** disability (if any)

Details of Acquired Brain Injury (ABI)

- Stroke Brain Infection Brain Tumour Brain Surgery Trauma (MVA) Epilepsy
 Trauma (falls) Professional fights Alcohol related Substance related Assaults
 Suicide attempts/blood loss Hypoxic (reduction of oxygen) Other Disabilities

Date of ABI

Please detail how the ABI impacts the client's life

Neuropsychological / Cognitive Assessment

Has the client had any of the following?

Neuropsychological / Cognitive Assessment

- Yes No

Date of assessment

(Please provide details of assessment and attached relevant documentation)

[Upload from computer](#)

No file chosen

AOD

Please provide details on alcohol and other drugs if any

Past history use (please list)

Frequency of current use

Current treatment

Has the client had any recent alcohol or substance detoxification or rehabilitation?

Mental Health

Please provide details if any

Current or history of psychiatric or mental illness

Formal diagnosis

Current mitigation / interventions
(include medications prescribed)

Has the client had any recent psychological or psychiatric assessments or admissions?

Physical Health

Please provide details if any

Current or history of physical or psychosocial health

Formal diagnosis

Current mitigation / interventions
(include medications prescribed)

Has the client had any recent physical or psychosocial assessments or admissions?

Forensic / Legal

Please provide details if any

- None Bond Parole Child custody / family dispute Other please state
 CCO/ CBO

Please attach copy of CCO/CBO (if any)

[Upload from computer](#)

No file chosen

Details

Is there a history of violent or sexual behaviours?

- Yes No

If yes please specify risks

Needs Assessment

How often does the client need personal help or supervision with activities or participation in the following life areas

	Unable to do OR always need help in the area	Sometimes needs help OR supervision in the area	Does not need help in this area but uses aides	Does not need help in this area and does not use aides
Self Care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobility	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Communication	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interpersonal interactions & relationships	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Learning, applying knowledge and general tasks and demands	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Education	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Community (civic) & economic life	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Domestic life	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Working	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Participation

To what extent does the person participate in the following life areas?

	Extent of participation
Getting around outside	<input type="text" value="Select response option"/>
Using Transport	<input type="text" value="Select response option"/>
Maintaining family relationships	<input type="text" value="Select response option"/>
Maintaining social relationships	<input type="text" value="Select response option"/>
Recreation or leisure activities	<input type="text" value="Select response option"/>
Working	<input type="text" value="Select response option"/>
Handling money	<input type="text" value="Select response option"/>

Attendant Care/ Personal Care

If you are referring to any of the services in Attendant Care, In Home Care, RIPL, Personal Care, Residential Support services please provide

Required hourly supports/ routine and allocated funded hours

	Morning (e.g., 7am -12pm, 7am -3pm)	Afternoon (e.g., 2pm - 8pm)	Evening (e.g., 3pm - 11pm)	Sleepover e.g., inactive sleepover (eg.11pm to 7am)
Monday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tuesday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Wednesday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Thursday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Friday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Saturday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sunday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Risks

Please use this section to identify and detail risk areas

	Details	Current Mitigation
Deliberate harm to self	<input type="text"/>	<input type="text"/>
Risk to others	<input type="text"/>	<input type="text"/>

Risk to property

Referral Goals

Please list the goals



Please provide any additional information

Please upload any supporting/ additional needed documents (if any)

Upload from computer

Choose File N...

Upload from computer

Choose File N...

Upload from computer

Choose File N...

Referrer Details

Name*

Title*

Organisation*

Address*

Phone*

Email*

Please outline current role with client*

Signature: (Name)*

Date*



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arbias Ltd. is a not-for-profit/for purpose national specialist disability service provider for acquired brain injury, high-complex needs, and comorbidities such as alcohol and other drugs, as well as training, education, and capacity building.

Celebrating 30+ years of service
Assuring quality care with programs supported by:



Registered
NDIS Provider

Registered WorkSafe
Provider

Registered TAC
Provider

DFH

FPI NSW