|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Completed Referral form and requested documentation to be emailed to**  **howcanwehelp@risenetwork.com.au** | | | | | | | | | | | | | | | | | |
| **1. Referrer Details** | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | Phone/Mobile: | | | | | |  | | | | |
| Relationship to Client: | |  | | | | | | | | | | | | | | | |
| Email: | |  | | | | | | | | | | | | | | | |
| Support Required:  (Please select as many as apply) | | Support Coordination | | | | | | | | Recovery Coach | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **2. Client Details** | | | | | | | | | | | | | | | | | |
| Title: *(eg. Mr, Ms, Mx)* | |  | | | | | | Surname: | | | | | |  | | | |
| First Name: | |  | | | | | | Preferred Name: | | | | | |  | | | |
| Date of Birth: | |  | | | | | | Country of Birth: | | | | | |  | | | |
| Phone / Mobile: | |  | | | | | | | | | | | | | | | |
| Email: | |  | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | |
| Living arrangements | | Live by myself  Live with family  Live with others  Supported Accommodation | | | | | | | | | | | | | | | |
| Inclusion:  *(Select all that apply to you)* | | Culturally & Linguistic Diverse (CALD)  Aboriginal  Torres Strait Islander  LGBTIQA+  Prefer not to say | | | | | | | | | | | | | | | |
| Gender Identity: | |  | | | | | | Pronouns Used: | | | | | |  | | | |
| Ethnicity/Nationality: | |  | | | | | | Preferred Language: | | | | | |  | | | |
| Disability? | | Primary: | | | | | |  | | | | | | | | | |
| Other: | | | | | |  | | | | | | | | | |
| Clients Communication abilities & requirements: | | Verbal  Non – Verbal  Read  Write  Braille | | | | | | | | | Advocate/representative presence  Communication device  Auslan  Interpreter required  Other: | | | | | | |
| Details: | | | | | | | | | | | | | | | |
| Do you require assistance with high intensity supports? Yes No | | Complex Wound management  Enternal feeding & management  Complex bowel care (Stoma Bag)  Tracheostomy management | | | | | | | | Ventilator management  Urinary Catheter management  Dysphagia management  Diabetes management | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **3. Funding Provider** | | | | | | | | | | | | | | | | | |
| Select from options: | | NDIS  Dept of Communities  Private  Other: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **4. NDIS Plan Details** | | | | | | | | | | | | | | | | | |
| Do you have funding for Support Coordination Services? | | | | | | | | Yes  No | | | | | | | | | |
| Do you have funding for Recovery Coaching Services? | | | | | | | | Yes  No | | | | | | | | | |
| NDIS Plan Number: | | |  | | | | | | | | | | | | | | |
| NDIS Plan Start Date: | | |  | | | | | NDIS Plan End Date: | | | | | |  | | | |
| Total Funding Amount: | | | $ | | | | | Total Funding Hours: | | | | | |  | | | |
| Remaining Funding Amount: | | | $ | | | | | | | | | | | | | | |
| **Please provide copy of current NDIS plan** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **5. Fund Management** | | | | | | | | | | | | | | | | | |
| Please select: | NDIA Managed  Plan-Managed – *Provide details below*  Self-Managed - *Provide details below* | | | | | | | | | | | | | | | | |
| Organisation: |  | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | |
| Phone/Mobile: |  | | | | | | | | | | | | | | | | |
| Email: |  | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **6. Decision Making** | | | | | | | | | | | | | | | | | |
| Do you make your own decisions? | | | | | Yes  No | | | | | | | | | | | | |
| Do you have a decision maker? | | | | | Yes  No ***If yes complete section 7*** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **7. Legal Guardian or Advocate / Guardian Details** | | | | | | | | | | | | | | | | | |
| Guardian / Family Member (Informal) | | | | | | | | | | | | | | | | | |
| Legal Guardian (appointed by WA State Administrative Tribunal) (Documentation required) | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | |
| Phone/Mobile: |  | | | | | | | | | | | | | | | | |
| Email: |  | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **8. Service Providers currently involved in your life** | | | | | | | | | | | | | | | | | |
| ***Accommodation, Community, Allied Health, Psychologists, PBS practitioners etc*** | | | | | | | | | | | | | | | | | |
| **Name / Organisation** | | | | | | **Contact Details** | | | | | | | | | | | |
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| **9. Signatory** | | | | | | | | | | | | | | | | | |
| Who is responsible for signing of documents required to proceed and commence services with Rise | | | | | | | | | | | | | | | | | |
| Client/ Individual | | | | | | | | | | | | | | | | | |
| Guardian / Family Member (Informal) | | | | | | | | | | | | | | | | | |
| Legal Guardian (appointed by WA State Administrative Tribunal) | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | |
| Phone/Mobile: |  | | | | | | | | | | | | | | | | |
| Email: |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **10. Consents** | | | | | | | | | | | | | | | | |
| The individual being referred has agreed that their information be shared with relevant Rise Staff for the purpose of providing required support. | | | | | | | | | | | | | | | | Yes  No |
| The individual/guardian being referred consents to release/obtain relevant information about them with/from other individuals and support services to assist with identifying my support needs.  The individual/guardian consent will be valid indefinitely unless otherwise stated or withdrawn in writing by myself/parent/guardian. The individual that I have the right to withdraw this consent at any time. The individual/guardian that Rise will always keep this information confidential and secure. | | | | | | | | | | | | | | | | Yes  No |
|  | | | | | | | | | | | | | | | | |
| To whom the individual/ guardian gives consent to Release and or Obtain Information: | | | | Family  Service / Funding Provider  Cultural Practitioners  Internal/External Auditor | | | | | Medical / Allied Health Professionals  Advocates  Legal Representative / Office of Public Advocate / Public Trustee | | | | | | | |
| To what the individual/ guardian gives consent to Release and or Obtain Information: | | | | Medical and Health  Reports and Assessments | | | | | Positive Behaviour Supports  Financial Arrangements and Funding Plans | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Individual or Guardian Name: | | | |  | | | | | | | | | | | | |
| Signature: | | | |  | | | | | | | | Date: | | |  | |