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| --- |
| **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** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|  |
| **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: |       |