



Thank you for contacting My Abilities regarding the opportunity for us to assist with support for you, your family member, or your client.

1. Participant's Details

Surname			
Given Name			
Preferred Name			
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/> Non Binary <input type="checkbox"/> (neither male or female)		
Date of Birth		Age	
Address			
Contact Details		Email	
Interpreter Required	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language	
Current Living Arrangement (Select from below)			
<input type="checkbox"/> With Family <input type="checkbox"/> Own Home <input type="checkbox"/> Private rental <input type="checkbox"/> State Housing <input type="checkbox"/> Supported Living <input type="checkbox"/> Other: _____			
Cultural Background			
<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Culturally and Linguistically Diverse (CALD) <input type="checkbox"/> None of the above <input type="checkbox"/> Prefer not to answer			

2. Referral Summary

Date of Referral		Referrer Name	
Agency / Self		Role	
Phone		Email	
Where did you hear about My Abilities?			
<input type="checkbox"/> Family <input type="checkbox"/> LC <input type="checkbox"/> NDIA <input type="checkbox"/> My Abilities Client <input type="checkbox"/> Other (please specify): _____			





3. Previous Service Provider

<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide the follow details Name of the Organization: Service Type: Provide contact details of contact person:
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4. Assessment Summary

5. Which of the following applies for your funding? (Please tick one or more if applicable.) 6. <input type="checkbox"/> Agency Managed <input type="checkbox"/> Plan Managed <input type="checkbox"/> Self-Managed 7. (Please note: This should be identified in your funding plan.)
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Funding Source/s	Total Funds Allocated	Total Funds to be allocated to My Abilities
<input type="checkbox"/> NDIS (Please attach NDIS plan)	\$	\$
<input type="checkbox"/> Department of Social Services	\$	\$
<input type="checkbox"/> Disability Services	\$	\$
<input type="checkbox"/> Mental Health Commission	\$	\$
<input type="checkbox"/> Self-funded	\$	\$
<input type="checkbox"/> Other	\$	\$
Total Funding	\$	\$

5. Diagnosis Information

Diagnosis	Details	Details of Treatment and support Required
Secondary Diagnosis (e.g. mental health, intellectual, physical, etc.)		
Communication	Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Other <input type="checkbox"/> (E.g. AUSLAN)	Other:

6. Guardian or Trustee Details

Please provide supporting documents and information		
Legal Guardian appointed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	





		Please provide supporting documents and information
	<input type="checkbox"/> Unknown	
Trustee appointed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

7. Support Services Required

Support Required	Please provide details below:
Accommodation/Host care/Respite	
In Home Support	
Community Access	
Support Coordination	
Therapeutic Support	
Other:	

8. Medical Overview

		Details	Please list and attach supporting documentation
Complex medical needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please describe details, e.g. PEG feed, catheter, ventilator]	
Medication prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please describe details, e.g. name of medication, dosage and how often it is taken]	
Other therapy and health services supporting client?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please describe details, e.g. psychiatrist Joe Bloggs, monthly appointments for last 2 years]	

9. Behavioural Overview





		Details	Please attach supporting documentation
Current behaviours of concern?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Previous behaviours of concern?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Positive Behaviour Support Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Any Restrictive Practice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

10. Risk Overview

Potential Risk/s		Details
Self-harm or suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]
Acute Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]
Alcohol or other drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]
Offending or contact with Justice system	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details, e.g. charges pending, criminal history, bail conditions, curfew, etc.]





Potential Risk/s		Details
Physical or verbal aggression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]
Hospital admission/s in last 2 years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]

11. Summary of Supports, Mobility, and Independence

		Details	Please Attach Supporting Documentation
Special dietary requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]	
Mobility aids or devices required?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]	
Personal care support required?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	[Please provide details]	

My Abilities staff will contact if more information is required. This referral will be sent to the panel for further consideration and to plan for the best support services.

Thank you for the referral.

