APLUS DISABILITY SERVICES

Referral Form

Date of Referral:	
Full Name of Client:	
Date of Birth:	
Address:	
Postal Address:	
Telephone No:	
Email Address:	
Is the Client Aboriginal or Torres Strait Islander decent:	
Language Spoken	
Is an Interpreter Required?	
Next of Kin - Emergency Contact:	
Relationship:	
Address:	
Email Address:	
Contact Number :	
Billing/ Funding:	
NDIS No:	
NDIS Contact Name:	

NDIS Rate:	
Name:	
Address:	
Email Address:	
Contact Number:	
Other Contact / Case Manager:	
Organisation:	
Address:	
Email Address:	
Contact Number:	
Referrer:	
Relationship:	
Address:	
Email Address:	
Contact Number:	

Information about the client (Interests, likes, dislikes):

Formal Diagnosis, Medical Information, Allergy Alerts:

Living Situation

Own Home / Living alone	Own home / with family member or others	Residential Care/Nursing home/SRS/ CRU etc.	Other

Cognition:

Very Good	Good	Fair	Poor

Communication

Verbal	Non Verbal	Aids	Other

Mobility

Independent	Assist	Walking Stick	Walking Frame
Manual Hoist	Shower Chair	Wheelchair	L Frame
Ceiling Hoist	Other		

Personal Care:

	No Support Required	Verbal Prompt	Physical Assistance
Shower / Bathing			
Toileting			
Grooming			
Dressing			

Behaviours (Does the client have a BSP , If so , please attach):

Goals

Required services days and times. Weekly / Fortnightly?:

Limits:
Maximum hours;
Maximum charges:
Maximum Kilometers:

Shift Routine:

Carer Preference (e.g male/female)

Carer Skills Required

Medication:	**Bowel Care:**	**Epilepsy:**	**Behaviour experience:**
Peg Feeding:	**Catheter:**	**Diabetes:**	**Car for transport:**
Hoist:	**Condom Drainage:**	**Dementia:**	**Full License:**

Other Relevant Information:

Please complete this referral form and forward, attention to Client Services to aplusdisabilityservices@gmail.com