

**JD Co-Ordination & Support Services- Intake and Referral Form**

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| **Note:** This form is a referral request only and does not mean JD Co-Ordination & Support Services will automatically proceed to an eligibility assessment. You will be notified if your request is not actioned. |

**Please complete sections 1-3** and then return to:

JD Co-Ordination & Support Services

PO Box 294

Werribee, VIC 3030

[intake@jdsupportservices.com](mailto:intake@jdsupportservices.com)

# Section 1

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service User Details** | | | | | | | | |
| **Given Name:** |  | | **Surname:** |  | | | | |
| **Preferred Name:** |  | | **Date of birth:** |  | | | | |
| **NDIS Participant #:** |  | | **NDIS Services Requested:** |  | | | | |
| **NDIS Plan Status:** |  | |
| **Contact Details** | | | | | | | | |
| **Home Address:** |  | | **Postal Address:** |  | | | | |
| **Phone:** |  | | **Mobile:** |  | | | | |
| **Email:** |  | | **Other:** |  | | | | |
| **Other Details:** | | | | | | | | |
| **Country of Birth:** |  | | **Are you of Aboriginal or Torres Strait Islander origin?** | Yes  No  Not stated/unknown | | | | |
| **Employment/Education Status:** | Comments: | | **Are you religious?** | Yes  No  Religion: | | | | |
| **Preferred Language:** |  | | **Communication Method:** |  | | | | |
| **Interpreter Required?** |  | |
| **Emergency Contact Details/Next of Kin** | | | | | | | | |
| **Name:** |  | | **Relationship to you:** |  | | | | |
| **Address:** |  | | **Phone:** |  | | | | |
| **Mobile:** |  | | | | |
| **Email:** |  | | | | |
| **Preferred Language:** |  | | **Communication Method:** |  | | | | |
| **Interpreter Required?** |  | |
|  | | | | | | | | |
| **Name:** |  | | **Relationship to you:** |  | | | | |
| **Address:** |  | | **Phone:** |  | | | | |
| **Mobile:** |  | | | | |
| **Email:** |  | | | | |
| **Preferred Language:** |  | | **Communication Method:** |  | | | | |
| **Interpreter Required?** |  | |
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| Section 2 | | | | | | | | |
| **Disability and Medical Condition Details** | | | | | | | | |
| **Disabilities** (please note all known disabilities) | | | | | | | | |
| **Primary Disability:** |  | | **Secondary Disability:** |  | | | | |
| **Other:** |  | | **Other:** |  | | | | |
| **Medical Conditions** (please note all known medical conditions) | | | | | | | | |
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| **Pension Details** | | | | | | | | |
| **Pension Type:** | If Other: | | **Pension Number:** |  | | | | |
| **Medicare:** | Yes  No  Not Eligible | | **Medicare Number:** |  | | | | |
| **Health Care Card:** | Yes  No  Not Eligible | | **Health Care Card Number:** |  | | | | |
| **Health Insurance:** | Yes  No | | **Health Insurance Provider:** |  | | | | |
| **Taxi Card:** | Yes  No  Not Eligible | | **Taxi Card Number:** |  | | | | |
| **Companion Card:** | Yes  No  Not Eligible | | **Companion Card Number:** |  | | | | |
| **Comments:** |  | | | | | | | |
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| Section 3 |  | | | | | | | |
| **Referral Details** | | | | | | | | |
| *(Presenting issues as identified by the service user, their representative or referrer)*  **Issues** (e.g. family / carer breakdown, referred person at risk due to falls, behavioural issues):  **Needs** (e.g. carer respite, equipment, personal care support, accommodation, behavioural support):  **Assistance** required (e.g. manual handling, personal care support, community access assistance): | | | | | | | | |
| **Court and Statutory Orders** | | | | | | | | |
| **Mental Health Orders:** | |  | **Orders relating to children:** | | |  | | |
| **Intervention Orders:** | |  | **Guardianship and Administration Orders:** | | |  | | |
| **Other type of court or statutory order:** | |  |  | | |  | | |
| **Alerts** | | | | | | | | |
| **Allergies:** | | | | | | | | |
| **Risks:** | |  | **Risk Management strategies:** | | |  | | |
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| Hazard and Risk Assessment Checklist completed:  Yes  No | | | | | | | | |
| Are there concerns that the participant is not capable of making their own decisions:  Yes  No | | | | | | | | |
| Enduring power of attorneys are in place:  Yes  No | | | | | | | | |
| Access to the referred service has been discussed with the participant?  Yes  No | | | | | | | | |
| Barriers to service: | | | | | | | | |
| Support required to address barrier to service: | | | | | | | | |
| **Current Assistive Technology** | | | | | | | | |
| Please list any assistive technology you currently use and note if it needs to be repaired, maintained or replaced of the next 12 months. | | | | | | | | |
| **Product** | | | | | **Repair** | | **Maintain** | **Replace** |
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| **Current Services** | | | | | | | | |
| Record services used in the last twelve months. Consider all health and community services | | | | | | | | |
| **Service Name:** |  | | **Service/s Provided:** |  | | | | |
| **Phone:** |  | | **Address:** |  | | | | |
| **Email:** |  | | **Other:** |  | | | | |
|  | | | | | | | | |
| **Service Name:** |  | | **Service/s Provided:** |  | | | | |
| **Phone:** |  | | **Address:** |  | | | | |
| **Email:** |  | | **Other:** |  | | | | |
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| **Phone:** |  | | **Address:** |  | | | | |
| **Email:** |  | | **Other:** |  | | | | |
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| **Email:** |  | | **Other:** |  | | | | |
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| **Service Name:** |  | | **Service/s Provided:** |  | | | | |
| **Phone:** |  | | **Address:** |  | | | | |
| **Email:** |  | | **Other:** |  | | | | |
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**Referral completed by:**

**Date:**