

**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

# 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[ ]  NoReligion:       |
| **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?** |       |
|  |  |  |  |
| 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) |
|       |
|       |
|       |
|       |
|       |
|       |
| **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:** |       |
|  |  |
| 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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| **Risks:**  |  | **Risk Management strategies:**  |  |
| 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** |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  |
| **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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| **Email:** |       | **Other:** |       |
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| **Phone:** |       | **Address:** |       |
| **Email:** |       | **Other:** |       |
|  |  |  |  |

**Referral completed by:**

**Date:**