carpentaria therapy services

ALLIED HEALTH REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Residential address:		Gender:	☐ M ☐ F ☐ Other
Contact numbers:	H: M:		

Does the participant identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Cultural Background:		Language/s spoken at home:	
Interpreter Required:	☐ Yes ☐ No		

Under the care of : ☐ Territory Families ☐ Public Guardian ☐ Other _____

Name:		Email:	
Phone:		Has the referral been discussed with the participant/guardian?	☐ Y ☐ N

Diagnosis/disability: (please attach supporting documentation)

Does the following apply to the participant? ☐ equipment use ☐ mobility aids ☐ vision impaired ☐ hearing impaired
If yes, please provide further information:

Previous supports / Services provided: (e.g. assessments, therapy, education/school supports, work supports)

Communication Status: ☐ verbal ☐ non-verbal ☐ Auslan/Key Word Sign ☐ AAC
e.g. PODD, eyegaze, switches

Comments: _____

SECTION 2: THERAPY SUPPORTS REQUESTED

☐ Speech Pathology ☐ Occupational Therapy ☐ Psychology ☐ Physiotherapy

Reason for Referral: e.g. emotions, behaviours, sensory, communication	

Priority Needs	Please let us know if the participant experiences any of the following:

☐ Swallowing difficulties (dysphagia) ☐ Falls ☐ Pressure Injuries ☐ Botox

☐ Risk to Self
- ☐ self-harm
- ☐ suicidal ideation
- ☐ risk taking behaviours
- ☐ accommodation break down
- ☐ substance abuse
- ☐ unable to access community (i.e. school)
- ☐ absconding (i.e. running away)
- ☐ cognitive impairment with limited supports

☐ Risk to Others
- ☐ violent
- ☐ other

As a primary carer, do you feel like you are experiencing / at risk of carer burnout? ☐ Yes ☐ No

Comments: _____

SECTION 3: FAMILY BACKGROUND INFORMATION (optional)

Parent/Guardian/Caregiver's Name/s:		☐ married ☐ de-facto ☐ separated ☐ other ☐ court orders
Significant life events/family stressors:		
Sibling Information: (name, age, relevant developmental details, medical needs, living arrangements etc)		

SECTION 4: FUNDING

NDIS Plan approved:	☐ Yes ☐ Pending (waiting NDIS response) ☐ Not commenced ☐ Not applicable				
NDIS number:		Plan start date:		Plan end date:	

Is the participant currently receiving any other Carpentaria services?

☐ Pathways ☐ Independent Living Services ☐ Employment and Training ☐ Other: _____

NDIS COS Details

Name:		Organisation:	
Email:		Phone:	
Plan Management	☐ Agency managed ☐ Plan managed ☐ Self-managed		

If Plan Managed, contact details of Plan Manager:

Name:		Organisation:	
Email:		Phone:	

SECTION 5: PRIMARY CONTACT DETAILS

Participant / Parent / Guardian			
Address:		Contact numbers:	H. M.
Email:			
Signature:		Date:	

SECTION 6: SECONDARY CONTACT DETAILS

Participant / Parent / Guardian			
Address:		Contact numbers:	H. M.
Email:			
Signature:		Date:	

SECTION 7: REFERRER DETAILS

Relationship to client:	☐ Guardian (completed above. No further details required) ☐ Other (complete referrer details) ☐ Coordinator of Supports (complete referrer details)		
Organisation (if app.):		Contact numbers:	B. M.
Name:			
Postal address:			
Email:			
Signature:		Date:	

Please tick documents that have been provided to assist in planning:

☐ Assessment reports ☐ NDIS Plan Goals ☐ Copy of NDIS Plan (optional)

Please send the completed referral form to *intake@carpentaria.org.au.*
For additional enquiries regarding this referral, please phone the Intake Officer on 8920 9400

Completing this form is not a guarantee that the service can be provided. Carpentaria requires completion of a service agreement for all services provided

! Please ensure all sections of this form are completed in order for us to process the referral in a timely manner.