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SPECIALIST DISABILITY ACCOMMODATION REQUEST FOR SERVICE FORM

PARTICIPANT DETAILS

Participant's full name:		Date of birth:	
Other names: (if applicable)		Age:	
		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Residential address:			
Postal address: (if different)			
Contact telephone number:	Home:	Mobile:	
Does the participant identify as:	Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/>		
Cultural background (optional):		Language/s spoken:	
Interpreter required:	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Guardian/nominee: (if applicable)			
Does the participant consent to this referral:	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is the participant a young person residing in a nursing home or aged care facility: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:			
Is the participant at risk in their current accommodation: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:			



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PARTICIPANT PROFILE INFORMATION

Primary diagnosis/disability:

Secondary diagnosis/disability:

NDIS plan goals:

Hobbies / likes:

Dislikes:

Communication preference: (e.g. Verbal, sign etc.)

Does the participant have behaviours of concern

Yes ☐

No ☐

If yes to the above, does the participant have a current Positive Behaviour Support Plan

Yes ☐

No ☐

In development ☐

Please select the documents that have been provided with this referral

OT Assessment ☐

PBSP ☐

Communication Assessment ☐

Risk Assessment ☐

Other (provide details) ☐



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GUARDIAN / NOMINEE DETAILS

Name:	
Organisation: (if applicable)	
Email:	
Phone:	

SUPPORT COORDINATOR DETAILS

Name:	
Organisation: (if applicable)	
Email:	
Phone:	

NDIS PLAN DETAILS

NDIS number:		Plan start:		Plan end:	
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SDA FUNDING DETAILS

SDA building type:		Number of bedrooms:	
SDA design category:			
SDA dwelling location:			



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SIL / CARE PROVIDER (if applicable)

Organisation:

Provider contact name:

Email:

Phone:

REFERRER DETAILS

Relationship to client:

Guardian (no further details required)

☐

Support Coordinator (complete details below)

☐

Name:

Organisation:

Postal address:

Business phone:

Mobile:

Email:

Signature:

Date:

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