carpentaria

SHORT TERM ACCOMMODATION REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Other names: (if applicable)		Gender:	☐ Male ☐ Female
Residential address:			
Postal address: (if different)			
Phone numbers:	Home: Mobile:		
Does the participant identify as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither		
Has the Participant consented to this referral?	☐ Yes ☐ No		
Primary diagnosis / disability: (please attach supporting documentation)			
Secondary disability(ies) or other presenting issues:			
Communication status: (eg. verbal, sign etc)			
Communication assessment:	☐ Completed and attached ☐ Not available ☐ Not applicable		
Personal mobility aids:			
Mobility aids required:	☐ Hoisting ☐ Commode ☐ Sarah Steady ☐ Any other Assistive Devices _____		
Does Participant have challenging behaviours?			
Does participant have a current Behaviour Support Plan (PBSP)?	☐ Yes Dated _____ (please provide a copy) → Has a PBSP review been requested ☐ Yes ☐ No ☐ No → Is a PBSP required? ☐ Yes ☐ No		

Please tick the documents that have been provided:

- ☐ PBSP
- ☐ Risk assessment
- ☐ Person centred plan
- ☐ NDIS plan goals
- ☐ Communication assessment
- ☐ Occupational Therapy assessment
- ☐ Copy of NDIS Plan (optional, assists in planning)
- ☐ Other (provide details) _____

SECTION 2: RATIO OF CARE AND COMMUNITY ACCESS

Requested ratio of support: ☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ Other _____

Is your plan funded for this? ☐ Yes ☐ No

Community access requirements:

SECTION 3: SHORT TERM ACCOMMODATION (RESPITE) REFERRAL

When is Respite required?

Start date:_____ Start time:_____

Start date:_____ Start time:_____

Frequency: ☐ Weekly ☐ Monthly ☐ Once only

Additional details:

SECTION 4: NDIS PLAN

NDIS Plan approved: ☐ Yes ☐ Pending (waiting NDIS response) ☐ Not commenced ☐ Not applicable

NDIS number:		Plan start date:		Plan end date:	

If not NDIS funded, what is the funding source? _____

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

SECTION 5: REFERRER DETAILS			
Relationship to client:	☐ Guardian (completed above, no further details required) ☐ Coordinator of Supports (complete referrer details)		
Organisation:		Contact numbers:	B: M:
Name:			
Postal address:			
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