Referral to Service Form

Objective: This form is used to refer a participant to a service provider, ensuring that all necessary personal, NDIS, and nominee information is collected to facilitate a smooth transition and delivery of services in accordance with NDIS guidelines.

Submission Instructions:

Please submit the completed referral form to [Email Address] or fax to [Fax Number]. If you have any questions, please contact us at [Phone Number].

This **Referral to Service** form ensures that all necessary participant, NDIS, nominee, and referral details are captured, facilitating a smooth handover of services while adhering to NDIS and privacy regulations.

Referral to Service Form

Participant Information

Full Name:

Date of Birth:

NDIS Number:

Address:

Phone:

Email:

Preferred Language:

Interpreter Needed? ☐ Yes ☐ No

Gender:

Cultural Background:

Indigenous Status (if applicable): ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None

Marital Status:

Personal Information

Medicare Number:

Health Insurance Provider (if applicable):

Concession Card (if applicable): ☐ Yes ☐ No
If yes, provide details:

Primary Emergency Contact Name:

Emergency Contact Phone:

Relationship to Participant:

Secondary Emergency Contact Name:

Secondary Emergency Contact Phone:

Relationship to Participant:

NDIS Information

NDIS Plan Start Date:

NDIS Plan End Date:

NDIS Plan Manager

Plan Manager Contact Details

Company:

Name:

Address:

Website:

Phone:

Email:

Current Support Coordinator *(if applicable)*

Name:

Company:

Phone:

Email:

Reason for the change *(if applicable)*:

Nominee Information (if applicable)

NDIS Nominee: ☐ Yes ☐ No

If yes, indicate type of nominee: ☐ Plan Nominee ☐ Correspondence Nominee

Nominee Full Name:

Nominee Date of Birth

Relationship to Participant:

Nominee Address:

Nominee Phone:

Nominee Email:

Nominee's Role/Authority:
☐ Financial Management
☐ Decision Making

☐ Service Coordination
☐ Other:

Referring Agency/Person Details

Referring Organisation/Agency:

Contact Person:

Phone:

Email:

Relationship to Participant:

Service Being Referred To

Service Provider Name:

Contact Person:

Phone:

Email:

Type of Service Required:

☐ Level 1 - Coordination of Support

☐ Level 2 – Coordination of Support

☐ Level 3 – Coordination of Support

☐ Psychosocial Recovery Coaching

☐ Plan mentoring and Capacity Building (CORE – Daily Living skills 01)

☐ Other:

Reason for Referral

Describe the participant's needs and why this referral is being made (include relevant background, goals, or specific requests):

Participant's Current Supports

List current services or supports the participant is receiving (including NDIS-funded and non-NDIS services):

Medical and Behavioural Information

Primary Disability:

Secondary Disability (if any):

Relevant Medical Conditions:

Allergies:

Behavioural Considerations (if any):

Consent to Share Information

I, , give consent for [Referring Organisation] to share my personal, NDIS, and nominee information with [Service Provider Name] for the purpose of facilitating the services I require.

I understand that I can withdraw my consent at any time by notifying [Referring Organisation] in writing.

Signature:

Date:

Service Provider Acceptance

This section is to be completed by the service provider after reviewing the referral.

☐ **Accepted** ☐ **Not Accepted** Reason:

Service Provider Representative Name:

Signature:
Date:

Comments or Additional Information: