

Richmond Fellowship NDIS Supports Referral Form

If you have a Mental Health clinical manager, see another health professional or community worker, you can ask them to help you complete this form. You can also contact us for assistance. **If a clinical manager, health professional or service provider is referring someone, they must involve the potential participant in making this application and have them sign it to be considered.**

Please email this form to joanne@rfact.org.au - once we receive your application we will contact you and organise a time to meet

The information contained in this Application Form is used for creating a RF record and assisting staff to work out how best to help you. Information is treated with the strictest confidence, unless you are identified as being at serious risk to either yourself or others. In this instance the Crisis Assessment and Treatment Team or emergency service will be contacted.

Surname: _____ Date of Birth: ____/____/____

Given names: _____

Current address: _____

Current contact no's: _____ Mobile: _____

Email address: _____

Are you: (please circle)	MALE / FEMALE / LBGTIQ	Are you of Aboriginal or Torres Strait Islander descent?	YES / NO
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Are you from a different (non-English) cultural background?	YES / NO	If 'YES', which culture do you identify with? Do you have any beliefs or practices you would like us to be aware of?
Do you need an interpreter?	YES / NO	

What is your current diagnosis?

Do you currently see any of the following health professionals on a regular basis? (Tick all that apply)

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Clinical mental health manager | If 'YES', who?: _____ Number _____ |
| <input type="checkbox"/> GP | If 'YES', who?: _____ Number _____ |
| <input type="checkbox"/> Psychiatrist | If 'YES', who?: _____ Number _____ |

Do you have a current NDIS Plan in place? Plan start and end date _____	YES / NO	NDIS Number	
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Do you have a plan manager? If yes who? _____	YES / NO
Is Support Coordination included in your plan?	YES / NO
Are you seeking a Support Coordinator from this referral? If no who is your Support Coordinator _____	YES / NO
Do you wish to participate in social and community group activities?	YES / NO
Do you wish to be supported by a peer mentor?	YES / NO
Do you consent to forwarding us your NDIS Plan?	YES / NO

If 'Yes' please include a copy of your plan or alternatively bring your plan to your first meeting with Richmond Fellowship.

Do you have arrangements in place with any of the following authorities? (Tick all that apply)

- National Disability Insurance Scheme (NDIS)
- Public trustee
- Guardian / Public guardian
- Mental Health Tribunal
- Police / Parole / Corrective Services
- Other: _____

Do you receive support from any other agency?	YES / NO	If 'Yes' please list them below:

Do you have anyone else who supports you, such as a family member?	YES / NO
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If 'Yes' ↓

Their name:
Phone:
Their relationship to you:

Their name:
Phone:
Their relationship to you:

Do you give us permission to contact these people?

YES / NO

Can you tell us a little about yourself? It is important you let us know how best we can support you.

Do you have any:

Physical disability? Y/N **Learning disability?** Y/N **Current/past drug or alcohol abuse?** Y/N

Chronic health problems? (eg. asthma, epilepsy allergies or concerns) Y/N If 'Yes' Please list them below so we can assist if needed.

Does the potential participant understand and consent to:

a) this referral;

b) Richmond Fellowship staff discussing the referral with the referring agency if applicable;

c) undergo an assessment with Richmond Fellowship staff; and

d) sign an exchange of information form so RF can commence contact with other agencies you may need to support you

Yes

No

Name (print): _____ **Signature:** _____ **Date:** _____
(Potential Participant)

Name (print): _____ **Signature:** _____ **Date:** _____
(Person making referral – if applicable)

Name of person completing this form: _____

Relationship to participant _____

Contact numbers: _____ **Mobile:** _____

Email address: _____