Inner Works DISABILITY SERVICES
INNER PEACE BEGINS HERE

SUPPORTED INDEPENDENT LIVING REFERRAL FORM

HOUSE / LOCATION ID: ……
FAMILY NAME: ……
GIVEN NAME: ……
DATE OF BIRTH: ……/……/……..SEX:……

PARTICIPANT INFORMATION

Participant's Full Name:

Referral Name:

Date of Birth:

Gender: Male ☐ Female ☐ Prefer not to say ☐ Other ☐

Residential Address:…… Postal Address (if different): ……

…….. ……

…….. ……

Phone Number:……..

Mobile:……..

Email ID:……..

Aboriginal/Torres Islander Yes ☐ No ☐

Country of Birth:

Language is spoken at home:……

The interpreter required Yes ☐ No ☐

Nominated Support Person/ Emergency Contact Person Name:……

Relationship with Person:……

Contact Number:……

Contact Email:……

Do you have a Case Manager? Yes ☐ No ☐

Name & Contact Details:……

Do you have Guardian / Public Trustee Appointed? Yes ☐ No ☐

Name & Contact Details:……

Do you have a GP/Nurse Practitioner? Yes ☐ No ☐

Name & Contact Details:……

HOUSE / LOCATION ID: …….
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DATE OF BIRTH: ……../……../……..SEX:……

SUPPORT REQUIRMENTS

Support Independent Living (SIL) ☐ Short

Term Accommodation (Respite) ☐ Daily

Support ☐

Current Financial Situation:

DSP Payment ☐ Income from Work ☐ Parenting Payment ☐ Sickness Benefits ☐ Carers Allowance ☐ Other ☐

Current Accommodation Details:

Own House ☐ Rent House ☐ Department of Housing ☐ Supported Living ☐ Nursing Home ☐ Other ☐

Participants NDIs Plan Details

NDIs Plan Number:

Plan Start Date:…….. Plan End Date:…….

Self Managed ☐ Plan Managed ☐ NDIA ☐ Plan Management provider ☐

Provider Contact Details:

Name:……

Phone Number:……

Email:……..

HOUSE / LOCATION ID: …….
FAMILY NAME: ……
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DATE OF BIRTH: ……../……../……..SEX:……

PARTICIPANT'S DISABILITY/MEDICAL CONDITION

Provide Medical Conditions including Mental & Physical Health

1. Any allergies you may be aware of?

   Yes ☐ No ☐ If yes, provide details

2. Do you have any mobility aids?

   Yes ☐ No ☐ If yes, provide details

3. Any hospital admissions in the last 12 months?

   If any, provide full details or attach a file

4. Is there any current Behaviour Management Plan?

   Yes ☐ No ☐ If any, provide full details or attach a file

5. Do you take regular medications (including depot injection)?

   Yes ☐ No ☐ provide details

6. Do you require support taking your medication?

   Yes ☐ No ☐ provide details

History and support

Forensic history or legal concerns

If any, provide full details

Drug and alcohol use

If you provide details including history of use and current use

(eg: smoking, alcohol, substances, etc

how much, how often, how many)

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SUPPORT NEEDS

Are there any tasks you find challenging?

(eg:shopping, cooking, etc.)

What support do you need?

Provide details

Detach of other service providers

(eg: therapy provider, other specialists)

If any (eg: OT, Speech Pathologist)

Please provide a recent Occupational Therapy Assessment if available

Contact Details of GP

Address & Phone Number:……..

……

……

Name of Psychiatrists:……

Address & Phone Number:……..

……

……

Case Manager/ Support Coordinator

Name:……

Phone Number:……

Email:……

HOUSE / LOCATION ID:…….

FAMILY NAME:……

GIVEN NAME:……..…

DATE OF BIRTH:……../……../…….SEX:……

CONSENT

I agree to permit Innerworks disability services to obtain verbal and written information from my health service providers to gather additional information to assist with my referral if needed. I consent to this referral being submitted for consideration of Innerworks services Residential accommodation services*

Participant's Name ……..

Signature …… Date ……/……/…….

Witness Name & Relationship …….

Signature …… Date ……/……/…….