Referral for Support Services

Participant's Personal Details

Name:

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Telephone #: **Mobile #:** **Email:**

Address: **Postcode:**

Name of School/ Other Service Provider:

Australian Residency Status: Citizen ☐ Permanent Resident ☐ Visa ☐ Details:

Are you currently registered with Disability Gateway Services? Yes ☐ No ☐

Do you have a National Disability Insurance Scheme (NDIS) package? Yes ☐ No ☐

Have you previously or are you currently receiving services from St Giles? Yes ☐ No ☐
If yes, please provide details:

Parent/ Guardian/ Person Responsible Details

Relationships: Parent ☐ Guardian ☐ Person Responsible☐

Name: Mr ☐ Mrs☐ Ms ☐

Telephone #: **Mobile #:** **Email:**

Address (if different from above)**:** **Post Code:**

Referring Agent Details

Name: Mr ☐ Mrs☐ Ms ☐

Organization/ Position:

Telephone #: **Mobile #:** **Email:**

Address (if different from above)**:**

Postcode:

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How will service(s) be funded?

NDIS **NDIS Number:**	☐	**MAIB**	☐
DHHS	☐	**Self**	☐
Compensable	☐	**Other Service Provider**	☐
ISP	☐	**No Current Funding**	☐

Medical

What is your/ the participant's medical condition and/ or diagnosis?

Do you/ the participant have a current Health Care Plan? Yes ☐ No ☐

Do you/ the participant have a current Seizure Management Plan? Yes ☐ No ☐

Do you/ the participant require medication to be administered when being supported? Yes ☐ No ☐

Do you/ the participant display behaviours of concern? Yes ☐ No ☐

If you, please describe:

Current Support Plans

Meal Management Plan	☐	
Bowel Management Plan	☐	
Drug Chart	☐	
Communication Plan	☐	
Transport Plan	☐	
Behaviour Management Plan	☐	
Health Support Plan	☐	
Other	☐	*Please provide details:*

Note: *Please attach any/ all relevant plans*

Are there any Court Orders or Parenting Orders in place? Yes☐ No ☐

If yes please provide details:

Do you or parent/ guardian/ person responsible require an interpreter? Yes ☐ No☐

If yes, what language?

Referral for Support Services

Support Requested

In Home Support	☐
Community Support	☐
Supported Accommodation	☐
Leisure and Lifestyle Services (Respite)	
Weekday Overnight	☐
Weekend Overnight	☐
After School Care (Peeps)	☐
School Holiday Program	☐

Times/ Location of Requested Support

Monday	Tuesday	Wednesday	Thursday
Times: Location:	Times: Location:	Times: Location:	Times: Location:
Friday	**Saturday**	**Sunday**	**Other**
Times: Location:	Times: Location:	Times: Location:	Times: Location:

Is there anything else you think that we should know?

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____

Signature of Referrer: **Date:**

Please contact the Case Coordination Team with any questions and return this form to St Giles.

North/ North – West
65 Amy Road, Newstead, Tasmania, 7250
Phone: 6345 7308
Fax: 6345 7373
Email: CaseCoordination@stgiles.org.au

South
11 Gant Street, Lenah Valley, Tasmania, 7008
Phone: 6238 1888
Fax: 6238 1818
Email: CaseCoordination@stgiles.org.au