Specialist Behaviour or Therapeutic Support Referral

Date of referral	

1. Participant Details				
Name				
Date of birth			NDIS number	
Email			Phone	
Address				
Ethnicity				
Interpreter required?	Yes ☐	No ☐		
Mobility issues?	Yes ☐	No ☐		
Requires transport?	Yes ☐	No ☐		
Care Situation (e.g., at home, in supported accommodation)				

2. NDIS Plan details	Please attach a copy of participants NDIS plan or NDIS goals and funding related to service requested
Is this the participants first plan?	Yes ☐ No ☐
How many plans has the participant had?	
Contact person for the NDIS plan? (i.e., support coordinator, case manager, carer, parent)	
Contact person phone	
Contact person email	
Plan Management (please select)	Agency Managed ☐ Plan Managed ☐ Self-Managed ☐
Plan manager	
Plan manager Phone	
Plan manager Email	
If self-managed, contact email for invoices	

3. Requested service	
Requested Service (please select)	Behaviour Management Plan ☐ Specialist Behaviour Support ☐ Developmental Education ☐ Functional Capacity Assessment ☐
Available hours of Behaviour Management plan funding	
Available hours of Specialist Behaviour Support funding	
Available hours of DE / FCA funding	

4. Carer and/or Nominee details			
Name		DOB	
Email		Phone	
Relation to participant			
Address			

Other carer/s?	
Details	

5. Diagnosis	
Diagnosis	
Date diagnosed	
Diagnosing Clinician/s	
Any Dual Diagnoses (mental health, learning, physical, intellectual, drug and alcohol)	

6. Medication	
Medication 1	
Name of prescribed medication	
Date prescribed	
Prescribing physician	
Management of what condition? (Please outline if the medication is for mental health condition, behaviour management or medical diagnosis)	
Who administers the medication (mentors, client self manages etc)	
Other information	

Medication 2	
Name of prescribed medication	
Date prescribed	
Prescribing physician	
Management of what condition? (Please outline if the medication is for mental health condition, behaviour management or medical diagnosis)	
Who administers the medication (mentors, client self manages etc)	
Other information	

Medication 3	
Name of prescribed medication	
Date prescribed	
Prescribing physician	
Management of what condition? (Please outline if the medication is for mental health condition, behaviour management or medical diagnosis)	
Who administers the medication (mentors, client self manages etc)	
Other information	

Medication 4	
Name of prescribed medication	
Date prescribed	
Prescribing physician	
Management of what condition? (Please outline if the medication is for mental health condition, behaviour management or medical diagnosis)	
Who administers the medication (mentors, client self manages etc)	
Other information	

7. Referrer Details				
Name				
Organisation				
Phone				
Email				
Role (please tick)	Support Coordinator ☐	Professional ☐	Family member ☐	Other ☐
If other (please specify)				

8. NDIS and Mainstream Services and Providers Involved Details		
	Name and Service	Address, email and phone number
General Practitioner		
Psychologist/counsellor		
Mental Health (clinician, case manager)		
Psychiatrist		
Paediatrician		
Specialists		
Physiotherapist		
Occupational Therapist		
Social Worker		
Support Coordinator		
Child Protection Worker		
Mentor/ Support Worker/s		
Domestic Violence Worker		
Juvenile Correction officer or Criminal Justice worker		

Drug and Alcohol		
Victim Support Sexual assault MVA		
Vocational employment officer (if relevant) Transition to work coordinator		
Centrelink social worker (if relevant)		

9. Known restrictive practices (management of behaviours of concern for example holding down, medication management, locking in room, or rules that prevent the participant from doing what they want etc.)

10. Presenting Concerns and reason for referral to our service (Behaviours of concern [kicking, biting, pushing etc], needs a PBS [to move or leave hospital or to attend work or school etc], support plan etc)

11. Relevant Assessments (within 18 month), please attach and tick where relevant	
Positive Behaviour Support Plan	
Support Plan	
Functional Assessment	
Diagnostic Assessment	
Sensory Profile	
Psychology Assessment	
Speech Assessment	
Other	

12. Requires development of	
Positive Behaviour Support Plan	
Functional Capacity Assessment	
Other	

13. Inclusive Service Needs
Strive Disability Support Services is an inclusive provider. We welcome referrals from all participants so please let us know if there are any considerations relating to culture, religion, values, beliefs and sexual expression that we can accommodate: