KALINA HEALTH AND COMMUNITY SERVICES
88 Reid Promenade JOONDALUP WA 6027
ABN: 49 662 005 863 Provider No: 4050065274
Ph: 0432 969 220 E: admin@kalinahacs.com.au

NDIS REFERRAL / INFORMATION FORM

Date of Referral/ Request :	

DETAILS OF THE PERSON MAKING THE REFERRAL /REQUEST FOR SUPPORT			
Name:			
Email:			
Phone:		**Mobile**:	

SUPPORT REQUIRED:

CLIENT/PARTICIPANT DETAILS			
Name:		**DOB:**	
Gender:	☐ Male ☐ Female ☐ Trans/Intersex/Another identity/undisclosed		
Address:			
Email:		**Mobile:**	
Preferred method of communication:	☐ Email ☐ Post ☐ Phone	**Do you identify as Aboriginal and/or Torres Strait Islander?**	☐ Yes ☐ No
Language spoken at home:		**Interpreter required:**	☐ Yes ☐ No
Contact Person:	Name: Phone Number:		

Is there a Guardianship and/or Administration order in place? *For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below*			☐ Yes ☐ No
Name of Guardian:			
Relationship to Participant:	☐ Partner ☐ Guardian ☐ Caregiver ☐ Other:	**Primary Carer**	☐ Yes ☐ No
		Lives with Participant	☐ Yes ☐ No
		Emergency Contact	☐ Yes ☐ No
Address:			
Email:			
Home Phone:		**Mobile:**	

CARE/CLINICAL NEEDS AND DIAGNOSIS	
Diagnosis:	
Diet: **If yes:**	Any issues with swallowing (Dysphagia)? ☐ Yes ☐ No Diet consistency: Fluid consistency:
Mobility (Walking/Transfer)	☐ Walk without aid ☐ Walk with mobility aid ☐ Unable to walk ☐ Uses wheelchair ☐ Hoist for transfer ☐ Falls risk
Skin:	☐ Wounds present ☐ Bruising ☐ Other skin condition:
Smoking:	☐ Yes ☐ No
Clinical:	☐ NGT/PEG ☐ IDC/SPC ☐ Tracheostomy ☐ Stoma ☐ Oxygen Tx ☐ pressure sores ☐ Diabetes ☐ Other:
Safety/ Behaviour/risks we should be aware of	
Triggers	
Behaviour management strategies	
Hobbies	
Restrictive practices in place?	☐ Yes ☐ No If yes, please describe:
Details of the Behavioural Support Therapist	
Do you require us to administer medication?	☐ Yes ☐ No

HEALTH MEMBERSHIP INFORMATION			
Medicare Number		**Expiry Date:**	
		Reference No.:	
Health Care Card		**Expiry Date:**	
Private Health Cover		**Membership No.:**	
		Reference No.:	

DOCTOR DETAILS	
Name	
Address	

Phone Number	
FOR SIL PARTICIPANTS ONLY	
Dentist Name/ PH	
Pharmacy/PH	
Companion Card	☐ Yes ☐ No
Taxi Vouchers	☐ Yes ☐ No
Smart Rider Card	☐ Yes ☐ No
Other Cards	

FUNDING			
☐ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIA managed participants)			
NDIS Number			
NDIS Plan Start Date		NDIS Plan End Date	

PERSONAL PREFERENCES	
Preferred Name	
Religious Requirements	
Cultural Requirements	
Other Considerations	

SAFETY CHECKLIST (Required for Home Visits)	**Yes**	**No**	**If yes, please provide details**
Does the client, or other occupants have a history of violent or aggressive behaviour?	☐	☐	
Does anyone at the client's property have a criminal history?	☐	☐	
Is there a history of drugs or alcohol misuse at the property?	☐	☐	
Does the client, or other occupants smoke?	☐	☐	
Are you aware of any occupant having an infectious disease? (i.e. chicken pox / Covid-19 / gastro, etc.)	☐	☐	
Has the client been diagnosed with dysphagia?	☐	☐	
Are there any pets at the client's premises?	☐	☐	
Does the client need an interpreter?	☐	☐	
Are there particular religious or cultural sensitivities to be aware of?	☐	☐	

Are there any other occupants or visitors likely to be present during home visits?	☐	☐	
In the event of emergency, who do we contact?			
Are there any other factors/safety risks we should be aware of (e.g. swallowing difficulties, epilepsy, sharps on premises etc.)?	☐	☐	

ACKNOWLEDGMENT			
I understand that: • These records are owned by this organisation; • Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties; • I can ask to see records and receive a copy; • Records are archived for a set period according to policy and procedure; • I understand that all information obtained will be kept confidential. To the best of my knowledge, the information provided in this form is true and correct.			
Referrer	Name/ Signature		
Signature of Participant or Parent/Caregiver:			
Name:		**Date:**	
Relationship to Participant:			