MY WAY
DISABILITY • AGED CARE

REFERRAL FORM

My Way Community Alliance Inc.

Perth 08 6146 6296 | referrals@myway.org.au
Geraldton 08 6182 1703 | midwest-wa-referrals@myway.org.au
Melbourne 03 9969 0300 | vic-referrals@myway.org.au
www.myway.org.au

PARTICIPANT DETAILS

Full name

Date of birth (DD / MM / YYYY)

/ /

Gender

◯ Male ◯ Female ◯ Other

Participant NDIS Number

Address

Phone

Mobile

Email

Alternative contact person

Full name

Contact Number

Emergency contact – Person 1

Full name

Contact Number

Emergency contact – Person 2

Full name

Contact Number

Current Living Arrangements (With family, alone, or sharing with others)

Cultural Background

◯ Torres Strait Islander
◯ Aboriginal
◯ Aboriginal & Torres Strait Islander
◯ None of the above

◯ **Culturally and Linguistically Diverse (CALD)** (Please specify below)

REFERRAL FORM

SOURCE OF REFERRAL

Self | Family | Agency | NDIA | LAC

Other e.g Support Coordinator
(Please specify)

Name, Contact Number + Email

NEXT OF KIN / SIGNIFICANT OTHER PERSON

Full name

Relationship

Address

Phone

Email

DIAGNOSIS

Please Provide Details if Applicable

Primary Diagnosis

Secondary Diagnosis

Assistance required with medication?

Does the individual have Epilepsy, Seizures, Asthma, Allergies?

Assistance required with mobility e.g., wheelchair, walker, hoists?

Any other safety concerns, or Behaviours of concerns etc ?

HOW DID YOU HEAR ABOUT US?

REFERRAL FORM

REASONS FOR THIS REFERRAL

Details if Applicable, Or Hours/Week

- ◯ Support Coordination Level 2, & Level 3
- ◯ Social, Civic and Community Participations
- ◯ Psychosocial Recovery Coach
- ◯ Daily Tasks / Domestic / Personal Care supports
- ◯ Short Term Accommodation
- ◯ CB-Increased social and community participation
- ◯ Supported Accommodation / ILO / SIL supports
- ◯ Plan Management
- ◯ Positive Behaviour Support

Therapy Support Services

- ◯ Occupational Therapist
- ◯ Plan Management
- ◯ Community Registered Nurse
- ◯ Speech Therapist
- ◯ Counsellor or Psychologist

Hours/Budget - If you know

NDIS

Who manages your NDIS funding?

◯ Agency Managed ◯ Plan Managed ◯ Self- Managed

If Plan Managed, provide Plan Manager contact details

Full name

Phone

Email

NDIS Number

NDIS Plan Start Date

NDIS Plan End Date

REFERRAL FORM

OFFICE USE ONLY

Referral Outcome ◯ Referral Accepted ◯ Referral not Accepted

Name/Position

ACCEPTED

Details

Allocation Date

Date entered on the database

Notes

NOT ACCEPTED

Details

Reason not accepted

Comments/Actions e.g., referred on to [name of service]