



Details of the Individual Requiring Support:		
Full Name:		
Preferred Name:		Gender:
Date of Birth:	Age:	Country of Birth:
Address:		
Home phone:		Mobile:
What is your primary Disability and/or current Medical condition/s?		
Communication Support or Interpreter services required? YES / NO If yes, please specify:		

Parent / Carer details:	
Name:	
Relationship to Client:	
Phone:	
Email:	
Participant is aware of this referral	YES / NO

Details of Referrer (if applicable):	
Name:	
Organisation: (if applicable)	
Relationship to Client:	
Date Referred:	
Phone:	
Email:	
Participant is aware of this referral	YES / NO

NDIS Ready	
Are you NDIS eligible?	YES / NO
Do you have an NDIS plan?	YES / NO
What date does your plan end?	
How is your plan managed?	
If plan managed, provide contact details:	
What is your NDIS number?	



Support Needs:

What type of supports are you looking to purchase?
 Eg. Social and community participation, in-home support, personal care?
 Eg. how many hours per week and what days and times do you prefer?

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Relevant background information:
 Eg. Functional impacts of disability, behaviors of concern, interests/hobbies

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Are you currently accessing other support services and if so, please detail?
 Eg. employment, GP, therapy, respite

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Signature of Referrer:

Name: _____

Signature: _____ Date: _____

PLEASE EMAIL COMPLETED NDIS REFERRAL TO: ndis@lutheranservices.org.au

The Intake Officer will advise you of the outcome of this referral or will provide you with appropriate alternate options if the referral does not meet program criteria.

<i>For office use only.</i>		<i>For office use only.</i>	
Date referral received		Service Name	
Received By (name)		Signature	