Professional Care Supports

Service Referral Form

Consumer Details:		
First Name:	Family Name:	
DOB:	Gender:	
Aboriginal	Torres Strait Origin	Culturally & Linguistically Diverse
Contact No:		
Email:		
Address:		
Primary Diagnosis/Disability:		
Secondary Diagnosis/Disability:		
Status:- Single	Married Divorced Separated Widowed Defacto	
Children: Yes	No	
Living Situation (Where Applicable): Living independently: Living with a Family member/carer: Homeless: Other (Specify):		

Guardian/Primary Carer Details: (Where Applicable)	
First Name:	Family Name:
Organisation:	
Position:	
Contact No:	
Email:	
Address:	

Referrer Details:	
First Name:	Family Name:
Organisation:	
Position:	
Contact No:	

Email:
Address:

NDIS Ref ID:		
Plan Start Date:	Plan Review Date:	Plan End Date:
Service Category being requested for Consumer: (Please fill in where relevant)		
Assistance with Daily Self Care (Core Supports) Funding Available in Plan: Hours of Support per Week:		
Assistance to Access Community (Core Supports) Funding Available in Plan: Hours of Support per Week:		
Improved Daily Living Skills (Capacity Building Supports) Funding Available in Plan: Hours of Support per Week:		
Improved Living Arrangements (Capacity Building Supports) Funding Available in Plan: Hours of Support per Week:		
Increase Social & Community Participation (Capacity Building Supports) Funding Available in Plan: Hours of Support per Week:		

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NDIS Details Introduction to Consumer
Please indicate consumer's current overall situation, general background information, history, like/dislikes, etc. (This avoids the consumer from repeating his/her story during the initial meeting with Karumah)

Presenting Risks/Complexities:
Indicate any risks/complexities identified by your organisation. Please send us risk assessments if available. This would allow Karumah to continue practices that have already been identified with consumer.

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Other Information

Does the consumer have a Behaviour Management Plan? Yes (Please Attach) No

Does the consumer have a Relapse Prevention Plan? Yes (Please Attach) No

Has the consumer/guardian consented to this referral? Yes No

For Office Use Only

Referral received on:

Actioned By: