# TeamHEALTH Referral – NDIS Supports

Team HEALTH
Supporting your mental health journey

TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

## Participant Details

Participant's Name ______ Preferred Name ______

NDIS Number ______ Start Date ______ End Date ______

Date of Birth ______ Gender ______

Email Address ______ Phone Number ______

Address ______

Country of Birth ______ Language at Home ______

Origin ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous ☐ Not Stated

Interpreter Required? ☐ No ☐ Yes

Public Guardian in Place? ☐ No ☐ Yes *Name & Phone Number* ______

Carer in Place? ☐ No ☐ Yes *Name & Phone Number* ______

Funding Management Type ☐ Self ☐ Plan ☐ Agency Managed ______

Plan Manager Contact *Name & Phone Number* ______

Support Coordinator Contact *Name & Phone Number* ______

______

Person Referring ______

Relationship to Participant ______

Contact Details ______

Referrer's Signature ______ Date ______

## Support Details (please add/remove support details as needed)

### Support One

Support Start Date ______ Support End Date ______

Support Item ______

Item Number ______

Description of Support (please include preferred day/s, times, worker and travel requirements)

______

______

______


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### Support Two

Support Start Date ______________________ Support End Date ______________________

Support Item ______________________

Item Number ______________________

Description of Support (please include preferred day/s, times, worker and travel requirements)

## Disability Details

Primary Disability/Concern ______________________

Secondary Disability/Concern ______________________

### Participant Goal 1

### Participant Goal 2

### Participant Goal 3 (add additional goals if needed)

### Other Required Parameters of Support

(If accessing the Community Hub, please indicate if participant wishes to utilise our pickup 10am-11am/drop off 2pm-3pm service)


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## Consent

I consent to this referral. I understand that this information will be stored on the TeamHEALTH system and that my details will be de-identified if they are used in reporting. I give permission for TeamHEALTH to discussion the information for the purposes of establishing and receiving supports.

| Signature of Participant | Signature of Public Guardian (if applicable) | Date |
|---|---|---|

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

If yes, name of person providing consent ______________________________

## Supporting Information Attached

☐ Risk assessment ☐ Supervision Order ☐ Behaviour Support Plan ☐ Community Management Order

## Completing this Form

- Please call TeamHEALTH on 1300 780 081 if you need any assistance completing this form.
- Send the completed form to: teamhealth@teamhealth.asn.au.
- TeamHEALTH will contact the participant or Public Guardian within two working days of receiving this form.

**Thank you for your referral**


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