



REFERRAL FORM

<b>Referral Date:</b>	
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<b>Client Details</b>	
Name	
Age	
DOB	
Phone	
Address	
Gender	
Aboriginal or TSI	
CALD	<ul style="list-style-type: none"><li>• Yes</li><li>• No</li><li>• Please Specify: _____</li></ul>

**Presenting Issues**

- Disability
- Mental Health
- Alcohol & Other Drugs (AOD)
- Family
- Accommodation
- Physical Health
- Employment
- Education
- Financial
- Legal/Law
- Other: \_\_\_\_\_

**Please Provide any further relevant information:**

**My Supports**

**Current Support:**

*Does the client receive any other type of support from family/community services/friends etc:*

- Yes
- No

**Details:****Core Support required from Assisst:**

*What type of support can Assisst provide?*

- Mental Health Support
- Daily Living Skills
- Medical Appointments
- Socialisation
- Meal Preparation
- Disability Support
- Care Co-Ordination
- Medical Supports
- Personal Care
- Case Management
- Domestic Support
- Transportation
- Groups
- Other: \_\_\_\_\_

**Details:****NDIS Support**

Is client eligible for NDIS funding package?

- Yes
- No
- Unsure

Has client completed NDIS Access

- Yes
- No

If Yes, Please provide NDIS reference number: \_\_\_\_\_

Does client need support with Pre-Planning

- Yes
- No

Other Details:

Has Client completed Planning with local area coordinator?

- Yes
- No

Other Details:

Has NDIS Plan been approved and funding allocated to Client:

- Yes
- No

Other Details:

### **Assist Program**

Please select:

- Mental Health
- Disability
- Aged Care

### **NDIS**

Please select:

- Support
- Planning
- Support Co-Ordination

**PLEASE SEND REFERRAL TO ASSISST ALONG WITH ANY SUPPORTING DOCUMENTS**

Email: [reception@assisst.org.au](mailto:reception@assisst.org.au)

Phone: 07 56352474