

# Referral Form

**Chosen Family** *Chosen Family offers diverse support services—from community access to personal care—empowering you to live your best, most independent life.*

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## 1. Participant Information

### Participant Name:

First: \_\_\_\_\_ Last: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

### Gender Identity:

Male  Female  Non-binary  Gender Diverse  Transgender  Other: \_\_\_\_\_

### Contact Details:

Phone Number: \_\_\_\_\_

Date of Birth (DD/MM/YYYY): \_\_\_\_\_

Participant Email: \_\_\_\_\_

### Residential Address:

Full Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

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## 2. Service Requirements

### Communication Preferences:

Does the client consent to be contacted?  Yes  No

Best person to contact:

Name: \_\_\_\_\_

Best mode of communication:  Text/SMS  Phone Call  Email

### Diagnosis & Consent:

Primary & Secondary Diagnosis: \_\_\_\_\_

Consenting Person's Name: \_\_\_\_\_

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## 3. Guardianship & Support Coordination

Is the participant with the Public Trustee and Guardian?  Yes  No

### Guardian Details (if applicable):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_



Relation to Participant:

Parent  Guardian  Public Guardian  Power of Attorney  Other

**Support Coordinator Details:**

Company Name: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

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## 4. Schedule of Support

Outline preferred hours (Start/Finish times).

Day	Start Time	Finish Time	Day	Start Time	Finish Time
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

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What type of services is the client seeking? (Select all that apply):

- Community Access
- Household Tasks
- SDA
- SIL Accommodation
- Capacity Building
- STA/Respite
- Drop in Support
- Personal Care
- LGBTQIA+ Training
- Support Coordination (Lvl 2)
- Support Coordination (Lvl 3)
- Other: \_\_\_\_\_

Which line items will Chosen Family be claiming for in this schedule of supports?  
Please list all with funding amounts for each support provided max a week:

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## 5. NDIS & Payment Details

NDIS Number: \_\_\_\_\_

Plan Dates: \_\_\_\_\_ to \_\_\_\_\_

### NDIS Plan Management:

Self-managed  Plan managed  NDIA Managed

Hours of support allowed per week: \_\_\_\_\_

### Plan Manager (if applicable):

Company Name: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Mobile: \_\_\_\_\_

### Payment Method:

- Option 1: Participant/Nominee managed (Provider sends invoice)
- Option 2: NDIA Managed (Provider claims from NDIA)
- Option 3: Registered Plan Management Provider

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## 6. Additional Client Details

### Care & Mobility:

- High care needs?  Yes  No  
Details: \_\_\_\_\_
- Mobile?  Yes  No  
Details: \_\_\_\_\_
- Manual handling/Hoists?  Yes  No  
Details: \_\_\_\_\_
- Mobility Equipment (Walkers, etc)?  Yes  No  
Details: \_\_\_\_\_
- Feeding requirements (Tube)?  Yes  No  
Details: \_\_\_\_\_

### Behavior & Environment:

- Behavioral issues?  Yes  No  
Details: \_\_\_\_\_
- Work with Pets?  Yes  No  
Specify: \_\_\_\_\_
- Preferences:  Smoker  Non-smoker

### NDIS Goals & Service Start Date:

Goals: \_\_\_\_\_ Proposed Commencement Date: \_\_\_\_\_



### How did you hear about us?

A Chosen Family Staff Member (Select below) - can select more than one.

- Traidy
- Lee
- Sara
- Nat
- Joshua
- Oriena
- Elisabeth
- Someone else( please specify name)

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- Google search
  - Online Ad
  - Event
  - LinkedIn
  - Social Media ( please specify)
  - Client ( please specify) \_\_\_\_\_
  - Other ( please specify) \_\_\_\_\_