

Request for Supports Referral Form

Participant Details:		
Full name:		
NDIS Number:		
Date of Birth:		
Gender:		
Phone:		
Email:		
Street Address:		
City/Suburb	State:	Postcode:

Provider Details	
Provider	uLaunch Pty Ltd
Address	Level 2 10 Bridge Street Sydney NSW 2000
Phone number (if available)	1800 113 233

Has the participant/guardian provided consent for this referral? Yes No

Referrer Details (Person submitting this form):	
Date of referral:	
Name of Referrer:	
Relationship to participant:	
Organisation:	
Phone:	
Email:	

Legal Guardian's Details:	
Full Name:	
Phone:	
Email:	
Address:	
Please indicate:	Legal Guardian <input type="checkbox"/> Community Guardian <input type="checkbox"/>

Mode of Communication		
Preferred Language:	English	
Interpreter required:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Preferred method of communication (Please tick all that apply)		
Face to Face <input type="checkbox"/>	Phone Call <input type="checkbox"/>	Text Message <input type="checkbox"/>
Letter <input type="checkbox"/>	Email <input type="checkbox"/>	Visual (Images/Videos) <input type="checkbox"/>
Contact with my advocate or representative <input type="checkbox"/>	Other <input type="checkbox"/>	

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Diversity and Cultural Background		
Country of Birth:	Australia	
Do you identify as:		
Aboriginal <input type="checkbox"/>	Torres Strait Islander <input type="checkbox"/>	Non-Indigenous <input type="checkbox"/>
Refugee <input type="checkbox"/>	Asylum Seeker <input type="checkbox"/>	Prefer not to say: <input type="checkbox"/>

Diagnosis:

Core Supports Required	Line Item
Support Coordination Level 2	
Support Coordination Level 3	

Participant's NDIS Details:		
NDIS Plan Start Date:		
NDIS Plan End Date:		
NDIS Fund Management:		
Agency Managed: <input type="checkbox"/>	Plan Managed: <input type="checkbox"/>	Self-Managed: <input type="checkbox"/>
Plan Manager Details: <i>If applicable</i>	Name:	
	Email:	
	Phone:	

Participant's NDIS Plan Goals:

Reason for referral:

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Risk Assessment	Yes	No
Does the participant have current forensic issues or legal matters?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant have a history of self-harm or suicidal behaviour?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant have a history of sex offences?	<input type="checkbox"/>	<input type="checkbox"/>
Does the participant experience violence in the home?	<input type="checkbox"/>	<input type="checkbox"/>
Are there safety concerns with the participant's accommodation?	<input type="checkbox"/>	<input type="checkbox"/>
Are there concerns regarding the participant having their basic needs met i.e., food, shelter etc?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any concerns regarding the participant's financial situation?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any mental health or behavioural issues (in addition to those discussed above)?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety hazards for uLaunch Staff members visiting the family home? Such as dogs, unsafe behaviour?	<input type="checkbox"/>	<input type="checkbox"/>
Is physical force ever used to prevent, restrict, or subdue the movement of the participant's body?	<input type="checkbox"/>	<input type="checkbox"/>
Is the participant restricted to accessing any parts of their environment, including all rooms in the house they live in, outside, items, or activities?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide details on any above responses as required:		

Please email completed referral form and any other relevant information or reports to NDISuLaunch@anguknight.com.au and we will respond within 3 business days.

Thank you for your referral.