Complete Nursing & Home Care

Form 127. Participant Referral Form

Participant Details			
Once completed please email this form to brisbanenorth@completenursing.com.au			
How did you hear about Complete Nursing and Home Care?			
Date of Intake		Referred By	
Participant First Name		Participant Last Name	
Gender		Date of Birth	
Languages Spoken		Cultural Origin	
Are you Aboriginal or Torres Strait Islander?	☐ Yes ☐ No		
Address		Suburb & Postcode	
Type of Address		Living Arrangements	
Home Phone		Mobile Number	
Email Address			
Are there any court orders/custody arrangements/restraining orders in place?	☐ Yes ☐ No		

Participants Contact Person and Emergency Contact			
Primary Contact Person			
First Name		Last Name	
Address		Suburb & Postcode	
Email Address			
Relationship to the Participant			
Emergency Contact Person			
First Name		Last Name	
Address		Suburb & Postcode	
Email Address			
Relationship to the Participant			

Provider Details and Funding			
NDIS Number		NDIS Plan Start Date	
Contact Name		NDIS Plan End Date	
Email Address			
☐ Self-Managed	☐ Plan Managed	☐ NDIA Managed	
If Plan Managed, provide Financial Intermediary details			
Invoice to (email address)			
Support Coordinator Name		Mobile Number	
Organisations Name		Phone Number	
Email Address			

Medical History and Details			
Primary Disability			
☐ Acquired Brain Injury	☐ Autism Spectrum Disorder	☐ Cerebral Palsy	☐ Deafblind (Dual Sensory)
☐ Dementia	☐ Developmental Delay	☐ Down Syndrome	☐ Genetic/Chromosomal Disorder
☐ Hearing Impaired	☐ Intellectual	☐ Mental Health	☐ Neurological (including Epilepsy and Alzheimer's)
☐ Psychiatric	☐ Physical	☐ Speech	☐ Vision Impaired
Primary Disability Details			
Secondary Disability			
☐ Autism Spectrum Disorder	☐ Cerebral Palsy	☐ Deafblind (Dual Sensory)	☐ Dementia
☐ Developmental Delay	☐ Down Syndrome	☐ Hearing Impaired	☐ Intellectual
☐ Mental Health	☐ Neurological (including Epilepsy and Alzheimer's)		☐ Psychiatric
☐ Physical	☐ Speech	☐ Vision Impaired	
Secondary Disability Details			

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Additional Information	
Does the Participant have any behaviours of concern?	☐ Yes ☐ No
If yes, provide the Behaviour Support Plan	
Does the Participant require communication support?	☐ Yes ☐ No
If yes, provide communication plan and contact person	
Does the Participant require meal/swallowing support?	☐ Yes ☐ No
If yes, provide details	
Does the Participant have a health condition?	☐ Yes ☐ No
If yes, provide details	
Does the Participant require support with medication?	☐ Yes ☐ No
If yes, provide details	

Support Requirements

Days and Times Required

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
Night							

Support Worker Preferences	
What are the expectations of the Support Workers?	
Will transport be required?	☐ Yes ☐ No

Note: that all transport will be invoiced to the participant directly and will not be drawn from the NDIS plan unlessspecifically funded

Type of Support Required

☐ Community Access	☐ Assistance with Self-Care
☐ Personal Care	☐ Domestic Activities
☐ Innovative Community Participation (Art Therapy)	☐ Innovative Community Participation (Dog Therapy)
☐ Active Overnight	☐ Sleepover
Does the Participant require a Registered Nurse of an Enrolled Nurse?	☐ Yes ☐ No