Guidestar™

Request for Service

Participant Details

Full Name			
Date of Birth		Age	
Gender	☐ Male ☐ Female ☐ Indeterminate		
Address			
Does the participant identify as part of the Gay, Lesbian, Bisexual, Transgender, or Intersex community?		☐ Yes ☐ No ☐ Unsure	
Is the participant from an Aboriginal or Torres Strait Islander background?		☐ Yes ☐ No ☐ Unsure	
Is the participant from Culturally and/or Linguistically Diverse background?		☐ Yes ☐ No ☐ Unsure	
Country of Birth		Preferred Language	
Is an interpreter required?		☐ Yes ☐ No ☐ Unsure	

Service Request Details

Referrer Details	
Name	
Relationship to Participant	
Organisation	
Address	
Contact Number(s)	
Email Address	
Date of Request	

Consent for Service	
Name	
Relationship to Participant	
Method of Consent	☐ Authorised on NDIA ARF (authorise contact with external service providers) ☐ Verbal consent

Service Request Information	
NDIS Number	
NDIS Plan Dates	
Service Type (i.e., support category, line item number)	
Funding Allocation / Hours Funded	
How will these supports be paid?	☐ NDIA (Myplace)
	☐ Plan Managed Plan Management Provider:
	☐ Self-Managed Invoices to be sent to:
Urgency of Referral	☐ High ☐ Medium ☐ Low ☐ Unsure
Preferences to allocated staff? (i.e., male or female, etc.)	☐ No ☐ Yes (please specify):
Reports to be sent to:	
Completed reports timeframe (i.e., prior to plan review date, etc.)	

Service Request Outcomes/Goals	
Purpose of Support	
Goal 1	
Goal 2	
Goal 3	
Known expectations of other key stakeholders:	

Contact Details

Parents / Family / Informal Supports	
Name	
Relationship to Participant	
Formal Relationship to Participant	☐ Legal Guardian ☐ Supportive Attorney ☐ Power of Attorney ☐ Administrator ☐ Other (please specify):
Address	
Contact Number(s)	
Email Address	
Special Considerations?	
Parents / Family / Informal Supports	
Name	
Relationship to Participant	
Formal Relationship to Participant	☐ Legal Guardian ☐ Supportive Attorney ☐ Power of Attorney ☐ Administrator ☐ Other (please specify):
Address	
Contact Number(s)	
Email Address	
Special Considerations?	

Support Coordinator	
Name	
Relationship to Participant	
Organisation	
Address	
Contact Number(s)	
Email Address	
Special Considerations?	
Other (i.e., house supervisor, advocate, etc.)	
Name	
Relationship to Participant	
Organisation	
Address	
Contact Number(s)	
Email Address	
Special Considerations?	

Supporting Participant Information

Primary and Secondary Disability/Disabilities (including documented level of intellectual disability if applicable)	
Formal Diagnosis of Mental Ill Health (if applicable)	
General Health (i.e., diabetes, asthma, epilepsy, etc.)	
Physical Support Needs (i.e., equipment, etc.)	
Communication (i.e., communicates through sign, use of visuals, etc.)	
Any Cultural Practices	
Family Support System	
Relationships (outside of family support system)	
Current Living Situation (i.e., family home, residential unit, etc.)	
Activities (list/describe educational programs, employment, respite, etc.)	
Is there a current advocate/previous advocate involvement?	
Have there been any recent changes or significant events? (i.e., illnesses, bereavement, service transitions, etc.)	
Has there been any experience (or witnessed) of personal trauma and/or abuse? (i.e., physical, sexual, emotional, financial, etc.)	
Have the following	☐ Communication Assessment (date completed):

assessments been completed? (please check box if yes, and include the date of last assessment)	☐ Sensory Assessment (date completed): ☐ Adaptive Behaviour Assessment (date completed):
Presenting / History / Evidence of the Following Behaviours: (please check box if applicable)	☐ Physical Assault ☐ Self-Injury ☐ Sexualised Behaviour ☐ Fire lighting ☐ Substance Misuse ☐ Suicidal Ideation
Are there any interventions or court orders in place?	☐ No ☐ Yes (please describe):
Is there current Justice System involvement?	☐ No ☐ Yes (please describe):
Is there current Child Protection involvement?	☐ No ☐ Yes (please describe):

Current Plans	
Current Plans/Assessments for the Participant (please check the box if there is a current plan/assessment):	☐ Risk Assessment ☐ Mental Health Plan ☐ Person Centred Plan ☐ Behaviour Support Plan ☐ Behaviour Response Plan
Data Collection	
Current Data Collection Tools	☐ STAR Charts / ABC Charts ☐ Frequency Charts ☐ Incident Reports ☐ Other (please describe):

Health and Other Supports	
General Practitioner	Name: Date of last health check:
Mental Health Support	Name/Organisation: Date of last assessment:
Dentist	Name: Date of last dental check:
Neurologist	Name: Date of last review/appointment:
Psychologist	Name/Organisation: Involvement dates:
Occupational Therapist	Name/Organisation: Involvement dates:
Speech Therapist	Name/Organisation: Involvement dates:
Behaviour Support	Name/Organisation: Involvement dates:
Other	Name/Organisation: Type of Support: Involvement dates:

Medication				
Prescribed Medication (prescribed by a general practitioner/psychiatrist)				
Medication Name	Dose / Frequency	Name of Prescribing Practitioner	Purpose of Medication	Date of Review
Other (i.e., over the counter, health food shop, prescribed by naturopath/homeopath, etc.)				
Medication Name	Dose / Frequency	Name of Prescribing Practitioner	Purpose of Medication	Date of Review
Has there been any recent medication changes?	☐ No ☐ Yes (please describe):			

Reason for Referral

Presenting Issue or Behaviour	
Describe the issue / behaviour	
When did this start?	
How often does it start?	
Where does this usually occur?	
What is the impact?	
What is the response from others to the behaviour?	
What is the outcome to the response?	
Possible reason for the behaviour?	

Risks and Impact

Negative impact on others	☐ Yes ☐ No
Loss or reduction in services	☐ Yes ☐ No
Increase in the severity of behaviour	☐ Yes ☐ No
Increase in the frequency of behaviour	☐ Yes ☐ No
Use of restrictive practices (please check the box that is applicable)	☐ Physical Restraint ☐ Mechanical Restraint ☐ Chemical Restraint ☐ PRN Medication ☐ Seclusion ☐ Other
Is the participant active on the Restrictive Interventions Data System (RIDS)	☐ Yes ☐ No