Request for Service – Positive Behaviour Support

Participant Details

Full Name			
Date of Birth		Age	
Gender	☐ Male ☐ Female ☐ Self-described (please specify):		
Pronouns	☐ He/Him/His ☐ She/Her/Hers ☐ They/Their/Theirs		
Address			
Email Address			
Phone Number			
Do you/does the participant identify as part of the Gay, Lesbian, Bisexual, Transgender, or Intersex community?	☐ Yes ☐ No ☐ Unsure		
Are you/is the participant from an Aboriginal or Torres Strait Islander background?	☐ Yes ☐ No ☐ Unsure		
Are you/is the participant from a Culturally and/or Linguistically Diverse background?	☐ Yes ☐ No ☐ Unsure		

Service Request Details

Referrer Details	
Name	
Relationship to Participant/Organisation	
Address	
Contact Number(s)	
Email Address	

Contact Details

Parents/Family/Informal Supports/Other	
Name	
Relationship to Participant	
Address	
Contact Number(s)	
Email Address	

Service Request Information	
NDIS Number	
NDIS Plan Dates	
Service Type Service category, line item number	☐ 11_022_0110_7_3 Specialist Behavioural Intervention Support ☐ 11_023_0110_7_3 Behaviour Management Plan Including Training in Behaviour Strategies ☐ Other (please specify):
Funding Allocation/Hours Funded	
How will these supports be paid?	☐ NDIA (Myplace)
	☐ Plan Managed Plan Management Provider:
	☐ Self-Managed Invoices to be sent to:

Reason for Referral

Service Request Outcomes/Goals	
Purpose of Support/ NDIS Goals	

Presenting Issue or Behaviour	
Describe the issue/behaviour	

Risks and Impact

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

Supporting Participant Information

Primary and Secondary Disability/Disabilities	
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., sign, use of visuals, etc.)	
Family Support System	
Relationships (outside of family support system)	
Current Living Situation (i.e., family home, residential unit, etc.)	
Activities (programs, employment, respite, etc.)	
Current advocate/previous advocate involvement	
Recent changes or significant events (i.e., illnesses, bereavement, transitions, etc.)	
Experience (or witness) of personal trauma and/or abuse	

Completed assessments	▭ Communication Assessment (date completed): ▭ Sensory Assessment (date completed): ▭ Adaptive Behaviour Assessment (date completed):
Presenting/history/evidence of the following behaviours	▭ Physical Assault ▭ Self-Injury ▭ Sexualised Behaviour ▭ Fire lighting ▭ Substance Misuse ▭ Suicidal Ideation
Interventions or court orders in place/justice system of child protection involvement	▭ No ▭ Yes (please describe):

Current Plans	
Current Plans/Assessments for the Participant	▭ Risk Assessment ▭ Behaviour Support Plan ▭ Mental Health Plan ▭ Behaviour Response Plan ▭ Person Centred Plan

Health and Other Supports	
General Practitioner	Name: Date of last health check:
Mental Health Support	Name/Organisation: Date of last assessment:
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: