Priority PLUS CARE

- Home Care
- NDIS Support
- Regional Outreach
- Aboriginal Care

NDIS Referral & Support Request Form

Please complete this form to refer a participant to Priority Plus Care. Our team will review the referral and contact you within 24–48 hours to discuss suitable support options.

Email: info@prioritypluscare.org.au **Phone: (02) 5836 6637**

Participant Consent

Has the participant (or their authorised representative) provided consent for this referral? ☐ Yes ☐ No

By submitting this referral, you confirm that consent has been provided for Priority Plus Care to contact the participant.

Participant Information

Full Name: _____

Gender: ☐ Male ☐ Female ☐ Identifies as other Phone: _____

Date of Birth: _____ Email: _____

Street Address: _____

Suburb: _____ State: _____ Postcode: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Through representative

Participant Background & Support Needs

What are the participant's goals?
(For example: independence, daily living, community access, housing, or skill development)

_____

_____

About the participant
(Please share any important information about their current situation, support needs, or routines)

_____

_____

Support worker preferences (if any)
(For example: gender preference, cultural considerations, language, or experience)

_____

_____

What is the participant's primary diagnosis? (if known)

Does the participant have any additional diagnoses? (if applicable)

Cultural & Identity Information

This information helps us provide culturally safe, respectful, and personalised support that aligns with the participant's identity, preferences, and community.

Does the participant identify as:

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both
- ☐ Prefer not to say

Communication Needs

Preferred Language:
- ☐ English
- ☐ Other: _____

How does the participant communicate?
- ☐ Verbal
- ☐ Non-verbal
- ☐ Uses assistive communication tools
- ☐ Other: _____

Interpreter required:
- ☐ Yes
- ☐ No

Are there any important considerations we should be aware of?
(For example: behaviours, medical needs, safety considerations, or support requirements)

Health and Support Considerations

Does the participant take regular medication?
- ☐ Yes
- ☐ No

If yes, please provide any important details:

Does the participant have a Behaviour Support Plan (BSP)?
- ☐ Yes
- ☐ No

If yes, please provide any important details:

Are any restrictive practices currently in place or required?
- ☐ Yes
- ☐ No

If yes, please provide any important details:

Services Required

What support is required? (Select all that apply)

Core Supports
Day-to-day support to build independence.

- ☐ Personal Care / Daily Living
- ☐ Community Participation
- ☐ Transport

Housing & Respite
Safe, supported accommodation and short-term stays.

- ☐ Short-Term Accommodation (STA)
- ☐ Supported Independent Living (SIL)
- ☐ Respite Care

Capacity Building
Supports to build skills, confidence, and independence.

- ☐ Support Coordination
- ☐ Capacity Building Supports

Other Services
Additional supports tailored to participant needs.

- ☐ Home Care Services
- ☐ Culturally Appropriate Support

Preferred Days (Optional)

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred Time (Optional)

☐ Morning ☐ Afternoon ☐ Evening

Authorised Representative

Full Name: _____

Organisation: _____

Relationship to Participant: _____

Phone: _____ Email: _____

NDIS Details

NDIS Participant Number: _____

NDIS Plan Start Date: ____ / ____ / ____

NDIS Plan End Date: ____ / ____ / ____

Support Coordinator (if applicable):

Name: _____

Phone: _____ Email: _____

Consent Confirmation

By submitting this referral, you confirm that consent has been provided for Priority Plus Care to contact the participant regarding this referral.

☐ I confirm consent has been provided

Referrer Name: _____ **Signature:** _____ **Date:** _____

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Scan the QR code to submit a referral online or connect with our team directly.