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| 1. Agency Details | |
| |  |  | | --- | --- | | **Referral Date:** |  | | **Name of Referrer:** |  | | **Referrers Agency:** |  | | **Postal Address:** |  | | **Phone:** |  | | **Email:** |  | |  |  |  |

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| 1. Participant Details | | | | |
| **Name of Participant:** | |  | | | |  |  |
| **Address of Participant:** | |  | | | |
| **Telephone of Participant:** | |  | | | |
| **Date of Birth:** | |  | **Gender:** | |  |
| **Marital Status:** | | ☐ Single ☐ Married ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Does the participant identify as:**  ☐ Aboriginal  ☐ Torres Strait Islander  ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Country of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Language at Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Disability:** ☐ Yes ☐ No

**Description:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Medical Management Plans must be provided (Diabetes plan, Epilepsy plan, Asthma plan etc)*

**Behaviours of Concern / Restrictive Practices:** ☐ Yes ☐ No

*If Yes, we will forward you a Risk Assessment form to complete prior to sending a quote*

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| 1. Funding Information | | | | | | |
| **NDIS Number:** | | |  | | | |
| **Plan Dates:** | | |  | | | |
| **Plan Manager Email for Invoices:** | | |  | | | |
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| 1. General Information | | | | | | | |
| **Service required:**   |  |  | | --- | --- | | ☐ | 0115 **Daily Tasks/Shared Living (Respite/Short Term Accommodation)** | | ☐ | 0115 **Daily Tasks/Shared Living (Medium Term Accommodation)** | | ☐ | 0107 **Assistance with Daily Life (Assistance with Self Care)** | | ☐ | 0115 **Home and Living (SIL)** | | ☐ | 0125 **Social and Community Participation** | | ☐ | 0125 **Assist-Travel/Transport** | | ☐ | 0136 **Group and Centre Based Activities** | | ☐ | 0116 **Innovative Community Participation** |   Please complete the below as required  **0115** **Daily Tasks/Shared Living (Respite)**  **Ratio required:**  *Note: Ratios are taken into consideration for group outings. We will quote for a provision of 1:1-day support rates for participants on 1:2 and 1:3 ratios if they decide not to join the group outing during their stay.*  ☐ **1:1 – Requires Full Assistance with Daily Tasks**   * Showering * Toileting * Dressing and undressing * Mobility assistance in the community * Behaviours that require full monitoring (eyes on, constant need for staff attention) * Requires full assistance and constant supervision in the community. * 1:1 Staff member present throughout a 24hr period   *Does not include Active Overnight. If you require Active Overnights, please call to discuss* *prior.*  **☐ 1:2 – Requires Some Assistance with Daily Tasks**   * Minimal showering assistance (assistance to get in and out of bath or shower) * Minimal personal care and dressing (assistance with, shoes, socks, hair brushing) * May require prompting to pick appropriate clothes and get ready for the day. * Supervision or occasional help eating or using cutlery. * May need staff to help with daily living choices. * Requires closer supervision in the community and on outings. * Can effectively join with a group on agreed upon outings for a period of up to 8 hours   **☐ 1:3 – Independent or Requires Prompting with Daily Tasks**   * A person who is independent in all areas of personal care including toileting, showering and brushing teeth * Can eat independently, make drinks for themselves and has good communication/social skills. * Understands road rules, social settings and can effectively join with a group on agreed upon outings for a period of up to 8 hours * Able to spend periods of time alone while staff attend to other duties   *Full Description of ratios and assistance required to be discussed with Wattle Tree Office staff if you have ticked 1:1 or 1:2 Ratio*  *Please note that if a participant requires more than the ticked ratio a phone call will be made to request a change to the original quote and must be signed off before the stay can continue.*  **Do you require Wattle Tree to provide transport to and from Respite/STA?** ☐ Yes ☐ No  **Preferred Days / Dates for supports:**  ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday   |  | | --- | |  |   **Reason for Referral:** | | | | | | | | |  | |  |  |
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| **Participant Desired Outcome:** | | | | | | | | |
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| **Where did you hear about us?** | | | |  | | | | |
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| **Name:** |  | | | **Date:** |  | | | |
| **Signature:** |  | | |  |  | | | |