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**NDIS Referral Form - Request For Service**

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| **Referrer Details** |
| **Contact person and position** |  |
| **Contact Number** |  |
| **Contact Email** |  |
| **Participant consent for referral** | Yes / No |
| **Participant Details** |
| **Plan Managed** |  |
| **Name** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **NDIS Participant Number** |  |
| **Plan start date** |  |
| **Plan End Date** |  |
| **Address** |  |
| **Phone** |  |
| **Email Address** |  |
| **Preferred Contact Person** |  |
| **Participants Preferred Contact Details** |
| **Name** |  |
| **Relationship To Participant** |  |
| **Address** |  |
| **Contact phone number** |  |
| **Email address** |  |
| **Special Considerations** |  |
| **Requested Provider Details** |
| **Service Provider Name** | Thinkshift Pty Ltd  | Contact: Andrew Reay |
| **Address** | 93 Howards Lane, Kyabram Vic 3620 |
| **Phone** | 0411 576 676 |
| **Email Address** | info@thinkshift.com.au |
| **Is this a new or existing support arrangement** | Existing | New |
| **Support Item / Categories Requested** |  |
| **Indicate Client Level of Support Ongoing?** | Yes (please provide details) | No |
| **Support Item Description** | Improved Daily Living |
| **Funds / Hours available to be used by Provider:** |  |
| **Details to Support Participant Plan Implementation** |
| **What are the participants NDIS goals for this plan period** (as per NDIS plan goals) |  |
| **What support is required to assist the participants achieve their goals:** | Counselling and psychotherapy sessions to support …… |
| **What are the current barriers that are preventing the participant from achieving their goals:** |  |
| **What are the impacts of these barriers on the participant / family or informal supports? (if applicable)** |  |
| **What areas of the participants’ current situation require attention:** (not listed as goals i.e. lack of informal supports, aging carer, risk issues) |  |
| **Confirmation of Request** |
| **Referral accepted** | Yes / No (reason for decline) ………… |
| **Name** |  |
| **Signature** |  |
| **Position** |  |
| **Contact Number**  |  |
| **Date** |  |
| **Please attach Participants NDIS Plan with this request** |

**Please send this completed referral form to:**

**Email:** **info@thinkshift.com.au**

**Clinic Phone Number: 0411 576 676**

**Thank you for the referral**