**YOD Reflections Referral Form**

Name of Person with Dementia: …………………………………………………………………….

Date of Birth ……………………………….

Sex ………………… Age …………

Street Address ……………………………………………………………………………………………………

Suburb, City ………………………………………………………………………………………………………

Email ………………………………………………………………………………………………………………

Phone (M) ……………………………………… Phone (H) …………………………………………………

Kind of Dementia: ……………………………………………………………………………………

**Existing Care Arrangements**

[ ]  Lives Alone [ ]  Lives with Family [ ]  Supported Accommodation [ ]  Residential care

Background: [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Not Aboriginal Torres Strait Islander

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to make referral: …………………………………………………………………………………

Referrers Contact details: ……………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: .....................................................................................................................

Relationship to Participant: …..…………………………………………………………………………………

Contact Number: ………………………………………………………………………………………………..

Contact Address: ………………………………………………………………………………………………..

Contact Email: ………………………………………………………………………………………………….

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NDIS Plan No: …………………………………… Support Co-ordination (hours) …………………………

Start Date: …………………………………….. End Date: ………………………………………………

Support Co-ordination: [ ] NDIA Managed [ ]  Plan Managed [ ]  Self-Managed

Plan Managers Contact Details: ……………………………………………………………………………….

**Current Supports and Circumstances**

|  |
| --- |
| Click or tap here to enter text. |
|  |
|  |
|  |
|  |
| **Risk Factors and areas of concern** |
| Click or tap here to enter text. |
|  |
|  |
|  |
|  |
|  |

**Participant preferences**

Include any cultural, language, communication, and support needs/preferences that the participant has:

|  |
| --- |
| Click or tap here to enter text. |
|  |
|  |
|  |

Any other relevant views of the participant, referrer or parent/carers

|  |
| --- |
| Click or tap here to enter text. |
|  |
|  |
|  |
|  |
|  |
|  |

**Signatures:**

All relevant parties should sign off to agree that the information on this form is correct Consent to contact Service providers assumed upon signing of this document. All parties must also sign separate service agreements to proceed with services.

*The participants have the right to access and correct the information held by us at any time.*



|  |  |
| --- | --- |
| Participant’s Signature |  |
| Name of Participant | Click or tap here to enter text. |
| Advocate/guardians signature |  |
| Name of Advocate/guardian  | Click or tap here to enter text. |
|  |  |
| Organisations Representative’s Signature |  |
| Name of organization Representative | Click or tap here to enter text. |
| Date:  | Click or tap here to enter text. |