Coordination Practice Australia

Referral for Specialist Support Coordination (Level 3)

Please complete all sections that apply.
Return by email to: enquiries@coordinationpractice.com.au
Enquiries: 0438 916 353

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1. Referrer Details

- **Referral date:**
- **Referrer name:**
- **Referrer role / position:**
- **Organisation (if applicable):**
- **Relationship to participant:**
  - ☐ Participant (self-referral)
  - ☐ Family member / carer
  - ☐ Support Coordinator (Level 1/2)
  - ☐ LAC / NDIA planner
  - ☐ Clinician (e.g. psychologist, OT, social worker)
  - ☐ Case worker / advocate
  - ☐ Other:
- **Phone:**
- **Email:**
- **Preferred contact method:**
  - ☐ Email
  - ☐ Phone
  - ☐ Text
  - ☐ Other:

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2. Participant Details

- **Participant full name:**
- **Preferred name (if different):**
- **Date of birth:**
- **Gender:**
- **Pronouns (if known):**

  ☐ She/her

  ☐ He/him

  ☐ They/them

  ☐ Other:

  ☐ Prefer not to say

- **Address:**

  _____

  _____

  _____

- **Mobile:**
- **Home phone (if applicable):**
- **Email (if applicable):**
- **Preferred language:**
- **Interpreter required?** ☐ Yes ☐ No

  If yes, language:

- **Best way to contact participant:**

  ☐ Phone

  ☐ Text

  ☐ Email

  ☐ Via referrer

  ☐ Other:

3. NDIS Plan Details

- **NDIS number:**
- **Name on NDIS plan (if different):**
- **Plan start date:**
- **Plan end date:**
- **Plan management type:**

  ☐ Self-managed

  ☐ Plan-managed – Plan manager name:

  Plan manager email for invoicing:

  ☐ NDIA-managed
- **Is Specialist Support Coordination (Level 3) already in the plan?**

  ☐ Yes – approximate hours/funding:

  ☐ No – seeking Level 3 at next plan review

  ☐ Unsure
- **Current support coordination provider (if any):**

  _____
- **Is there a behaviour support plan in place?** ☐ Yes ☐ No
- **Is there a functional capacity assessment available?** ☐ Yes ☐ No

(Please attach a copy of the current NDIS plan and any relevant reports if possible.)

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4. Reason for Referral – Complexity and Risk

Please briefly describe why you are referring to **Specialist** Support Coordination (Level 3) rather than standard support coordination.

- **Main reasons for referral (tick all that apply):**

  ☐ Complex disability and/or health needs

  ☐ High risk of plan failure or crisis

  ☐ Multiple agencies involved (e.g. health, justice, child safety, housing)

☐ Significant barriers accessing or using NDIS supports

☐ Recent hospitalisation or mental health crisis

☐ Breakdown in current supports or providers

☐ Need for targeted, time-limited specialist input

☐ Other:

- **Brief summary of current situation and key barriers (2–6 sentences):**

- **Any identified risks or vulnerabilities?** (e.g. self-harm, suicide risk, violence, exploitation, homelessness, child safety)

- **Any safety plans or risk management plans in place?** ☐ Yes ☐ No
    - If yes, please briefly describe or attach:

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5. Current Supports and Services

Please list current key supports and providers:

- **Disability supports:**
- **Health / mental health supports:**
- **Housing / homelessness supports (if applicable):**
- **Justice / child safety / other systems (if applicable):**
- **Informal supports (family, friends, carers):**
- **Any current conflicts or breakdowns with providers or services?**

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6. Goals for Specialist Support Coordination

What are the main goals or outcomes you hope CPA can help with over the next 3–6 months? (Please prioritise 2–4 key goals.)

1.
2.
3.
4.

Any specific issues you want CPA to focus on first?

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7. Accessibility and Communication Needs

- **Does the participant have any access needs?** (tick all that apply)

  ☐ Mobility / physical access

  ☐ Vision

  ☐ Hearing

  ☐ Communication (e.g. AAC, Easy English)

  ☐ Cognitive / memory

  ☐ Sensory (e.g. autism-related)

  ☐ Other:

- **Any preferences for how CPA should communicate or meet?**
  (e.g. time of day, location, gender of coordinator, cultural considerations)

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8. Consent and Information Sharing

Participant consent is required for CPA to accept this referral and to share information as needed for coordination.

- **Who is providing consent?**

  ☐ Participant

  ☐ NDIS plan nominee / legal guardian (name):

  _____

- **Consent for CPA to:**

  Contact the participant: ☐ Yes ☐ No

  Contact the referrer: ☐ Yes ☐ No

  Contact other providers/services (with participant consent): ☐ Yes ☐ No

- **Information sharing preferences or restrictions (if any):**
- **Participant signature (or nominee/guardian): _**
- **Date:**

(If completing electronically, typed name and date is accepted as consent.)

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9. Attachments (Optional but Helpful)

Please attach any of the following that are available and relevant (with consent):

☐ Current NDIS plan

☐ Behaviour support plan

☐ Functional capacity assessment

☐ Recent clinical or allied health reports

☐ Risk or safety plans

☐ Other: _____

10. Additional Comments

Any other information that would help CPA respond to this referral:

Submission

Please email this completed form (and any attachments) to:
Email: enquiries@coordinationpractice.com.au

For urgent matters or to discuss a referral before sending, please call:
Phone: 0438 916 353