NDIS General Request Form

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Thank you for providing the following information. This general information will allow our team to prepare for your appointment and ensure the relevant equipment is available.

Please complete ALL sections, once completed please email to refer@indigosolutions.org.au

Customers Details

Name:	
Date of Birth:	
Phone:	
Email:	
Address:	
Suburb:	
Postcode:	
Indigenous status:	Choose an item
Country of Birth:	
Main Language spoken:	
Interpreter required:	☐ Yes ☐ No

Health Professional Details

Name:	
Organisation:	
Type:	☐ OT ☐ PT ☐ SP
	☐ Other:
Email:	
Phone:	

Carer / Parent / Alternate Contact

Name:	
Phone:	
Email:	
Relationship to customer:	

Funding

☐	NDIS participant #:	
	Plan Start Date:	Plan end date:
	NDIS plan goals:	
	How is Capacity Building managed in your plan? ☐ NDIA Managed ☐ Self-Managed ☐ Plan Managed *complete details below	
	*Plan Manager: Email:	

If you believe you are eligible for funding under a separate arrangement, please call us on (08) 9381 0600.

Background Information

Primary diagnosis	
Other Relevant medical history	
Reason for referral	Summary of why the referral has been sent. What are the difficulties the person is having? What are their strengths / abilities? Include any relevant details relating to the person, their carers and environment.
Equipment requests	Please list any specific equipment items you wish to view. Please note, although we will endeavour to obtain these for the appointment, there is no guarantee of availability.
Current equipment used	What relevant equipment is the person currently using? Why is this not sufficient?
Mobility / Transfers	e.g. method of mobility and transfers, level of assistance required
Communication	e.g. difficulties with hearing, vision, speech, devices used, level of assistance required
Behaviours of concern	e.g. can become agitated in new environments
Other necessary information	e.g. height, weight, bariatric, petite

Please ensure **ALL** sections have been completed.

Consent

Do you give consent to Indigo recording your information?	☐ Yes ☐ No
Do you give consent to Indigo to liaise with Health Professional and / or Alternate Contact listed above?	☐ Yes ☐ No

☐ I understand that I can withdraw my consent at any time, however I understand that this could impact my service delivery.

Customers Name:		Date:	

Signature:	X

Third Party Authority on behalf of Customer (only complete if relevant)

Reason for customer incapacity or inability to sign:

Reason.

☐ **Consent given by authorised representative** Name of authorised representative: Relationship to customer:	**OR**	☐ **Informed consent or agreement obtained** by (name of health professional): via (method of collection): *e.g. video call, in person* and customer answered "yes" or "no" to above questions by: *e.g. nodding or shaking head, saying yes or no*

Date		Contact number	

Signature:	X