|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Participant Details** | | | |
| **Name** | |  | |
| **Date of Birth** | |  | |
| **Address** | |  | |
| **Email Address** | |  | |
| **Phone Number** | |  | |
| **NDIS number** | |  | |
| **Plan dates** | |  | |
| **How many plans has the participant had** | |  | |
| **Contact person for NDIS plan** | | (i.e. case manager, carer, parent) | |
| **NDIS plan** | | (Please attach plan)  Please enter amounts on | |
| **Aboriginal and Torres Strait Islander** | |  | |
| **Requires an interpreter, transport or has mobility issues** | |  | |
| **Other relevant information** | |  | |
| 1. **Diagnosis** | | | |
| **Diagnosis** | |  | |
| **Date Diagnosed** | |  | |
| **Diagnosing Clinician/s** | |  | |
| **Any Dual Diagnoses** (mental health, learning, physical, intellectual, drug and alcohol) | |  | |
| 1. **Medication** | | | |
|  | **Medication 1** | | **Medication 2** |
| **Name of prescribed medication** |  | |  |
| **Date prescribed** |  | |  |
| **Prescribing physician** |  | |  |
| **Management of what condition?** (please outline if the medication is for mental health condition, behaviour management or medical diagnosis) |  | |  |
| **Who administers the medication (mentors, client self manages etc)** |  | |  |
| **Other information** |  | |  |
|  | **Medication 3** | | **Medication 4** |
| **Name of prescribed medication** |  | |  |
| **Date prescribed** |  | |  |
| **Prescribing physician** |  | |  |
| **Management of what condition?** (please outline if the medication is for mental health condition, behaviour management or medical diagnosis) |  | |  |
| **Who administers the medication (mentors, client self manages etc)** |  | |  |
| **Other information** |  | |  |
| 1. **Referrer Details** | | | |
| **Date of referral** | |  | |
| **Name** | |  | |
| **Agency** | |  | |
| **Position** | |  | |
| **Email Address** | |  | |
| **Phone Number** | |  | |
| **Address** | |  | |
| **Plan Management (please select)** | | Agency Managed  Plan Managed  Self-Managed | |
| **If Plan or Self-Managed, contact email for invoices** | |  | |
| **Service Requested**  **(please select)** | | Support Coordination (Level 2)  Specialist Support Coordination  Behaviour Support  Specialist Behaviour Support  Carer Capacity  Child capacity  Capacity Building | |
| Recommended Service Booking | |  | |
| Line Item/s Available to BST | |  | |

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| 1. **Plan details** (the funding issued in plan and current balance in all line items) | | | | | | |
|  | | | **Plan amounts** | | **Funding available** | |
| **CB Daily Activity** | | |  | |  | |
| **Improved Relationships:** | | |  | |  | |
| **Core** | | |  | |  | |
| **Transition to Work** | | |  | |  | |
| **Plan Management** | | |  | |  | |
| **Travel** | | |  | |  | |
| **Finding and Keeping a Job** | | |  | |  | |
| **Increased social and community participation** | | |  | |  | |
| **Other** | | |  | |  | |
| 1. **Carer details** (the funding issued in plan and current balance in all line items) | | | | | | |
| **Name** | |  | | | |
| **Relationship to Participant** | |  | | | |
| **D.O.B (if applicable)** | |  | | | |
| **Care Situation (e.g. at home, in supported accommodation)** | |  | | | |
| **Contact number** | |  | | | |
| **Email** | |  | | | |
| **Address** | |  | | | |
| **Other Carer/s?** | |  | | | |
| 1. **NDIS and Mainstream Services and Providers Involved Details** | | | | | | |
|  | **Name and Service** | | | **Address, email and phone number** | | |
| **General Practitioner** |  | | |  | | |
| **Psychologist/counsellor** |  | | |  | | |
| **Mental Health** (clinician, case manager) |  | | |  | | |
| **Psychiatrist** |  | | |  | | |
| **Paediatrician** |  | | |  | | |
| **Specialists** |  | | |  | | |
| **Physio** |  | | |  | | |
| **Occupational Therapist** |  | | |  | | |
| **Social Worker** |  | | |  | | |
| **Support Coordinator** |  | | |  | | |
| **Child Protection Worker** |  | | |  | | |
| **Mentor/ Support Worker/s** |  | | |  | | |
| **Domestic Violence Worker** |  | | |  | | |
| **Juvenile Correction officer or**  **Criminal Justice worker** |  | | |  | | |
| **Drug and Alcohol** |  | | |  | | |
| **Victim Support**  **Sexual assault**  **MVA** |  | | |  | | |
| **Centrelink social worker (if revenant)** |  | | |  | | |
| **Vocational employment officer (if relevant)**  **Transition to work coordinator** |  | | |  | | |
| 1. **Known restrictive practices** (management of behaviours of concern for example holding down, medication management, locking in room, or rules that prevent the participant from doing what they want etc..) | | | | | |
|  | | | | | |

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| 1. **Presenting Concerns and reason for referral to our service** (Behaviours of concern [kicking, biting, pushing etc], needs a PBS [to move or leave hospital or to attend work or school etc], support plan etc) |
|  |
| 1. **Risk Assessment** (within two weeks) |

|  | Y | N | Unknown | Comments |
| --- | --- | --- | --- | --- |
| Previous Attempts on own life |  |  |  |  |
| Previous serious attempts |  |  |  |  |
| Family history of suicide |  |  |  |  |
| Major psychiatric diagnosis |  |  |  |  |
| Major physical disability/illness |  |  |  |  |
| Separated/widowed/divorced |  |  |  |  |
| Loss of job/activity |  |  |  |  |
| Expressed suicidal ideas |  |  |  |  |
| Has plan/intent |  |  |  |  |
| Expressed high level of distress |  |  |  |  |
| Hopelessness/perceived loss of coping or control over life |  |  |  |  |
| Recent significant life event |  |  |  |  |
| Reduced ability to control self |  |  |  |  |
| Current misuse of drugs/alcohol |  |  |  |  |

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| 1. **Risk Assessment** (within two weeks) |

|  |  |
| --- | --- |
| Protective Factors | Comments |
| Good family support |  |
| Friends |  |
| Social |  |
| Has plans for future |  |
| Motivated |  |
| Other |  |
| **Risk Factors** |  |
| Lives in isolation |  |
| Financial difficulties |  |
| In a domestic relationship |  |
| Other |  |

|  |  |
| --- | --- |
| 1. **Relevant Assessments** (within 18 month), please **attach** and tick where relevant | |
| Positive Behaviour Support Plan |  |
| Support Plan |  |
| Functional Assessment |  |
| Diagnostic Assessment |  |
| Sensory Profile |  |
| Psychology Assessment |  |
| Speech Assessment |  |
| Other |  |
| 1. **Requires development of** | |
| Positive Behaviour Support Plan |  |
| Support Plan |  |
| Functional Assessment |  |
| Diagnostic Assessment |  |
| Sensory Profile |  |
| Psychology Assessment |  |
| Speech Assessment |  |
| Other |  |
| 1. **Treatment Plan** | |
|  | |

Signature:

Name:

Position: