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| 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 ManagedPlan Managed Self-Managed |
| **If Plan or Self-Managed, contact email for invoices** |  |
| **Service Requested** **(please select)** | Support Coordination (Level 2)Specialist Support CoordinationBehaviour SupportSpecialist Behaviour SupportCarer CapacityChild capacityCapacity 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)
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| --- | --- |
| 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 |  |

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| 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: