

NDIS Referral Form

To be eligible for MIFWA NDIS services you must be between 18-65 years old, have a primary psychosocial disability and an NDIS plan.

Consumer Details

Full Name

Gender

Address

Contact number

Email DOB

Referrer Details (if this is a self-referral, please leave this section blank)

Referrer Name

Agency Role/Relationship

Contact number Email

Source of Referral

Phone Email In Person

How did you hear about us?

Clinical Supports (if applicable)

Case Manager

Service

Contact Number Email

NDIS Information

What type of support are you seeking:
(Tick all that apply)

- Support Coordination
- Specialist Support Coordination
- Recovery coach
- Assistance with daily life
- Assistance to access the community
- Mentoring and skill development

How is your NDIS funding managed?
(Tick all that apply)

NDIA Managed Plan Managed Self-Managed

Are you currently receiving NDIS supports? If yes, from what organisation(s)

Presentation

Mental Health Diagnosis

Does the person have a current risk assessment (if yes, please attach)	Yes	No
Verbal/physical aggression	Yes	No
AOD challenges	Yes	No
Is there a community treatment order in place?	Yes	No
Was the person admitted to hospital in the last 6 months?	Yes	No
Has the person been informed of the referral?	Yes	No
Legal or forensic issues (if yes, please outline below)	Yes	No

Consent to share information

Referrer Signature

Date

This referral form collects information to assist MIFWA staff to help people get access to the NDIS services they may need. By signing this form, I consent to be referred to MIFWA, and give MIFWA permission to contact my referrer/clinical supports. MIFWA will contact my referrer/clinical supports to obtain information relevant to providing care and services to me. If this is a self-referral, I consent for my clinical supports to be contacted and to obtain information relevant to providing care and services to me. I understand that I can withdraw from this referral or from the referred service at any time. All information will be treated confidentiality and will only be used for the purposes stated in this form.

Consumer/guardian signature

Date

Please submit this form to: info@mifwa.org.au Referrals can also be made via our website: