Victorian Continence Resource Centre
NDIS Continence Service - Referral Form

Continence Foundation of Australia

Date completed: **Completed by:**

Participant Details

Participant name:

NDIS number:

Participant address:

Is this supported disability accommodation? *(Please tick)* ☐ **SRS** ☐ **SDA** ☐ **Other**

Date of birth: **Gender:**

Phone: **Email:**

Referrer Details

Referrer name:

Relation to participant: *(Please tick)* ☐ Support Coordinator ☐ House Support ☐ Next of Kin ☐ POA ☐ Parent ☐ Other:

Organisation:

Mobile: **Office phone:**

Email:

Reason(s) for Appointment *(Please tick)*

☐ Continence Assessment/Report ☐ Review/Follow Up ☐ Therapy

☐ Bladder ☐ Bowels ☐ Bed Wetting

☐ Condom Drainage/Training ☐ Products Recommendations ☐ Toilet Training (Need 10+ hours)

☐ Catheter Training ☐ Catheter Change ☐ Other:

☐ Nurse Assisted Training (Check Funding)

Appointment Location *(Please tick)*

☐ Telehealth (Video/Telephone) ☐ External/Home Based *(N.B. exceptional circumstances only - approval required - maximum 30 minutes travel)*

Disability Details *(Please tick)*

☐ ABI ☐ Physical ☐ Neurological

☐ Intell/Dev ☐ ASD ☐ Mental Health

☐ Cerebral Palsy ☐ Non-verbal ☐ Spinal Cord Injury

☐ Spina Bifida ☐ Down Syndrome ☐ Other:

☐ Further Medical Information

Payment Details *(Please tick one)*

☐ NDIS Portal Claim ☐ Invoice to Participant ☐ Invoice to Financial Plan Manager

Plan Manager Invoice – Name, Email & Phone:

Appointment Screen

Will anyone else be present during the appointment: *(Please tick)* ☐ Yes ☐ No

Please list all attendees and relationship to participant:

Physical Function (Mobility, Dexterity, Weight)

Are there any physical changes: *(Please tick)* ☐ Yes ☐ No

If yes, please provide details:

Communication (Hearing, Speaking, Language, Understanding)

Are there any communication challenges: *(Please tick)* ☐ Yes ☐ No

If yes, please provide details:

Is an Interpreter required: *(Please tick)* ☐ Yes ☐ No

What language interpreter is required?

Behaviours of Concern

Is there any history of behaviours of concern: *(Please tick)* ☐ Yes ☐ No

If yes, please provide recommended procedure for communicating with the participant. Please note, our staff are not able to implement any restrictive practices.

Does the participant have a restrictive practices plan: *(please tick)* ☐ Yes ☐ No

If yes, please provide a copy of the plan

NDIS Registered Service Provider details: Continence Foundation of Australia

Clinical practice details, location and trading name:

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