

Victorian Continence Resource Centre NDIS Continenence Service - Referral Form



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:

How did you hear about our service:

Reason(s) for Appointment (Please tick)

- | | | |
|--|---|---|
| <input type="checkbox"/> Continence Assessment/Report | <input type="checkbox"/> Review/Follow Up | <input type="checkbox"/> Therapy |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Bowels | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Condom Drainage/Training | <input type="checkbox"/> Products Recommendations | <input type="checkbox"/> Toilet Training (Need 10+ hours) |
| <input type="checkbox"/> Catheter Training | <input type="checkbox"/> Catheter Change | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Nurse Assisted Training (Check Funding) | | |

Appointment Location (Please tick)

- | | |
|---|--|
| <input type="checkbox"/> Telehealth (Video/Telephone) | <input type="checkbox"/> External/Home Based (N.B. exceptional circumstances only - approval required - maximum 30 minutes travel) |
|---|--|

Disability Details (Please tick)

- | | | |
|---|--|---|
| <input type="checkbox"/> ABI | <input type="checkbox"/> Physical | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Intell/Dev | <input type="checkbox"/> ASD | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Non-verbal | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Other: |

Payment Details (Please tick one)

- | | | |
|--|---|--|
| <input type="checkbox"/> NDIS Portal Claim | <input type="checkbox"/> Invoice to Participant | <input type="checkbox"/> 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: Continenence Foundation of Australia

Clinical practice details,
location and trading name:

Continenence Foundation of Australia
Suite 1, 407 Canterbury Road, Surrey Hills, VIC 3127
Phone: (03) 9816 8266 ABN 85598926929
E info@continenencevictoria.org.au **W** continenence.org.au