NDIS & Clinical Continence Services
Referral Form

Continence Foundation of Australia

Date of request:

Participant Details

Participant name:

Date of Birth: **Gender:**

NDIS number:

Participant address:

This address is *(Please tick)* ☐ **Own/Family Home** ☐ **SDA/Supported Accommodation**

☐ **RAC/Nursing Home** ☐ **Other**

Phone: **Email:**

Please note who these details are for if not for the participant directly.

Referrer Details

Referrer name:

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

☐ Accommodation Service ☐ Legal Guardian/POA ☐ Advocate ☐ Other

Organisation:

Phone: **Email:**

Who is the best person to contact:
Please provide relationship and contact details if not already listed.

How did you hear about our service:

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 ☐ Nurse Provided Training

☐ Other:

Appointment Location *(Please tick)*

☐ Telehealth (Video/Phone) ☐ Community/Home Based
(N.B. exceptional circumstances - approval required - max 30 mins travel)

Disability Details *(Please describe and tick)*

Disability/Diagnoses *(Please detail and tick below as relevant):*

☐ Acquired Brain Injury ☐ Physical ☐ MS or other neurodegenerative

☐ Intellectual/Dev. Delay ☐ Autism Spectrum Disorder ☐ Mental Health

☐ Cerebral Palsy ☐ Non-verbal ☐ Spinal Cord Injury

☐ Spina Bifida ☐ Down Syndrome ☐ Other:

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Payment Details *(Please tick one)*

☐ NDIS Agency Managed ☐ Self Managed ☐ Invoice to Financial Plan Manager
☐ Privately Paying ☐ Other:

Invoice Details for Private, Self and Plan Managed:

Name: Organisation (if relevant):

Phone: Email:

Aboriginal and Torres Strait Islander *(Please tick one)*

☐ Neither Aboriginal nor Torres Strait Islander ☐ Aboriginal
☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

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

Health Conditions

Allergies	☐ Yes	☐ No	Describe:
Anaphylaxis	☐ Yes	☐ No	Describe:
Asthma or other Respiratory	☐ Yes	☐ No	Describe:
Diabetes	☐ Yes	☐ No	Describe:
Cardiovascular Disease	☐ Yes	☐ No	Describe:
History of Urinary Tract Infections	☐ Yes	☐ No	Describe:

Any other health information you would like us to be aware of?

Does the participant take regular medication: ☐ Yes ☐ No

If yes, please provide a list or GP letter

GP Contact Details:

NDIS Registered Service Provider Details: Continence Foundation of Australia

Phone: 1800 92 92 62
Email: clinical@continence.org.au
ABN: 84007325313

Melbourne Office:
Suite 1, 407 Canterbury Road,
Surrey Hills, VIC 3127

Sydney Office:
6 Holker Street,
Newington, NSW, 2127