

NDIS & Clinical Continence Services Referral Form



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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe:
Anaphylaxis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe:
Asthma or other Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe:
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe:
Cardiovascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe:
History of Urinary Tract Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> 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