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| **Participant Details** | | | | | | | | | | | | |
| Name: | |  | | | | | | | Date of Birth: | | |  |
| Email: | |  | | | | | | | Phone: | | |  |
| Address: | |  | | | | | | | | | | |
| Have you used Enhance before? | | | | | | Yes (Re-referral)  No  Yes (More than 2 years ago) | | | | | | |
| Do you use other DSA/Scope services? | | | | | | Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No | | | | | | |
| Primary Disability: | | | | | |  | | | | | | |
| Mental Health Diagnosis: | | | | | |  | | | | | | |
| **What is the reason for referral?** (Briefly describe reason and other important information) | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Person Making the Referral** | | | | | | | | | | | | |
| Name: |  | | | | | | Organisation: | | | | |  |
| Phone: |  | | | | | | Relationship with Participant: | | | | |  |
| Email: |  | | | | | | | | | | | |
| **Key Decision Maker of the NDIS Plan** | | | | | | | | | | | | |
| Name: |  | | | | | | Interpreter Required? | | | Yes  No | | |
| Phone: |  | | | | | | If Yes, specify language: | | | | | |
| Email: |  | | | | | | | | | | | |
| **Next Point of Contact** | | | | Participant  Person Making Referral  Key Decision Maker | | | | | | | | |
| **NDIS Plan Details** | | | | | | | | | | | | |
| NDIS Plan Number: | | | | |  | | | Plan Start Date: | | |  | |
| Plan Attached? | | | | | Yes  No | | | Plan End Date: | | |  | |
| How will funds be claimed in the NDIS plan?  Direct Claim via NDIS portal | | | | | | | | | | | | |
| Plan Managed, details:  Self-Managed, details: | | | | | | | | | | | | |
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| **Types of Delivery that we offer** | | | | | | | | | | | | |
| Outreach | | | Clinician travelling to a suitable location of participant’s choice, within no more than 30 minutes travel from one of our clinics. This may be the family home, school, day program or workplace etc. This incurs a travel charge of 30 minutes each way per appointment. As per the NDIS price Guide this is charged at the same rate as the service booked. | | | | | | | | | |
| Clinic | | | Participant attending appointment at one of the Enhance clinic locations (Mascot, Campbelltown or Kingsgrove) | | | | | | | | | |
| Telehealth | | | Service completed via videoconferencing or phone call. | | | | | | | | | |
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| **Referral Process** | | | | | | | | | | | | |
| Send completed referral form and a copy of the NDIS goals and funds available in the requested categories to **referrals@ehs.org.au** | | | | | | | | | | | | |
| Intake will send you a service plan and consent forms. These need to be signed and returned as per NDIS requirements. Once all signed and sent back, funds are then confirmed with the funding entity | | | | | | | | | | | | |
| Once all is confirmed, the referral process will be considered complete. The Enhance wait list for clinical services varies and we will do our best to keep you informed. | | | | | | | | | | | | |

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| **Behaviour Support Intervention and Training (Improved Relationships: Item Numbers 11022 & 11023)**  ***Minimum 6 months left on the plan to complete service delivery*** | | | | | |
| Amount allocated to Enhance: | | Item 11022 | $ | Item 11023 | $ |
| Tick all that apply:  1 behaviour of concern only  2 to 3 behaviours of concern  Behaviour(s) occur in 1 setting only  Behaviour(s) occur in 2 to 3 settings  There is a previous Behaviour Support Plan  There are or may be Restrictive Practices, if  checked, how many? | | Other Important Information: | | | |
| Type of Delivery: | Specify location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telehealth ONLY (regional or limited funds) | | | | |

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| **Psychology Assessment & Therapy (Improved Daily Living: Item Number 15\_054)** | | |
| Amount allocated to Enhance: | | $ |
| Tick all assessments wanted:  Cognitive assessment & report (Min 10 hrs)  Housing / service needs assessment (10 – 15 hrs)  Finding and keeping a job – Employment related assessment and support  Other, specify: | | |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic, choose:  Kingsgrove  Mascot  Campbelltown  Moss Vale  Telehealth | |
| Tick all that apply:  Therapy (Understanding emotions, therapy and skill development)  Finding and keeping a job – Employment related counselling  Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other, specify: | | |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic, choose:  Kingsgrove  Mascot  Campbelltown  Telehealth | |

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| **Counselling Therapy or Training (Improved Daily Living: Item Number 15\_043)** | | |
| Amount allocated to Enhance: | | $ |
| Tick all that apply (Each 10 – 12 hours):  Counselling Therapy | |  |
| Type of Delivery: | Outreach (incurs return travel charges), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic, choose:  Kingsgrove  Mascot  Telehealth | |

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| **Registered Nurse Assessment & Training (Improved Daily Living: Item Number 15\_406)** | | |
| Amount allocated to Enhance: | | $ |
| Tick all that apply (Each 10 – 12 hours):  Epilepsy management plan  Pressure care plan  Non-invasive respiratory support e.g. CPAP  Urinary catheter support plan  Bowel care plan (Required for PRN medication) | | Tick all that apply (Each 15 hours):  Enteral feeding plan e.g. PEG  Diabetes plan  Health & wellbeing management plan (8 hrs) |
| Type of Delivery: | Outreach (incurs return travel time), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Speech Pathology Assessment and Therapy (Improved Daily Living. Item Number 15\_622)**  ***Minimum 6 months left on the plan to complete service delivery (unless agreed upon)*** | | |
| Amount allocated to Enhance: | | $ |
| Tick all assessments wanted:  Oral eating & drinking care plan (OEDCP) / Mealtime assessment (Min 10hrs for review only included travel)  Oral eating & drinking care plan (OEDCP) / Mealtime assessment (Min 15hrs for new / complex) | | |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Tick all that apply:  Communication assessment & report (Min 12 hrs if in clinic and 15 hrs if outreach)  Speech therapy on a regular delivery (Min 10 hrs but additional is strongly recommended)  Frequency: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other, specify: | | |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic, choose:  Kingsgrove  Mascot  Campbelltown  Telehealth only | |

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| **Occupational Therapy Assessment & Therapy (Improved Daily Living: Item Number 15\_617)**  ***Minimum 6 months left on the plan to complete service delivery (unless agreed upon)*** | | |
| Amount allocated to Enhance: | | $ |
| Tick all assessments wanted:  Functional (12 hrs)  Home and community safety (12 hrs)  Activity of daily living (Min 10 hrs)  Seating / Pressure care (14 hrs)  Powered mobility (Min 14 hrs) | | Assistive technology (Min 14 hrs)  Home modifications (Min 12 hrs)  Housing support (SDA & SIL) (30 hrs)  Sensory (12 hrs) |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Tick all that apply:  Therapy (manual handling, falls prevention, upper limb therapy (10 hrs)  Sensory Therapy (min 10 hrs if coming to a clinic location – as travel will come from the total hours, outreach usually requires additional hours)  Weekly  Fortnightly  Monthly  Other, specify: | | |
| Type of Delivery: | Outreach (incurs return travel), specify location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic, choose:  Kingsgrove  Mascot  Campbelltown  Telehealth | |