

# INTEGRATED SERVICE RESPONSE PROGRAM

## Referral Form



PARTICIPANT DETAILS	
<b>Name:</b> Title: First Name: Last Name:	Date of birth (dd/mm/yyyy): Gender:
<b>Address:</b> Unit Number: Street Name: Suburb:	Street Number: Street Type: State: Postcode:
<b>Contact Details:</b> Telephone: Email:	
<b>Cultural:</b> Aboriginal or Torres Strait Islander Status: Country of Birth: Residency/Visa category status: Main language spoken at home: Other language: How well does the Participant speak English: Is an Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Ndis Information:</b> Is the individual a participant of the NDIS? <input type="checkbox"/> Yes <input type="checkbox"/> No NDIS plan number (if known):	
<b>Legal Responsibility:</b> Does the participant have a legal guardian? <input type="checkbox"/> Yes (please provide details on page 6) <input type="checkbox"/> No Does the participant have involvement with any of the following? <input type="checkbox"/> Public Guardian <input type="checkbox"/> Public Advocate <input type="checkbox"/> Child and Youth Protection Service (CYPS)	
<b>Consent</b> Where information is shared with another service provider, a separate consent to share information form should also be completed and attached (see Attachment A). Consent to collect information: <input type="checkbox"/> Yes <input type="checkbox"/> No Consent to share information: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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### Participant Primary and other significant disabilities

Please select primary disability and any other significant disabilities

	Primary Disability	Other Disability
Intellectual (including Down Syndrome)		
Specific learning/Attention Deficit Disorder (ADD) (other than intellectual)		
Autism (including Asperger's syndrome and Pervasive Development Delay)		
Developmental Delay		
Physical		
Acquired brain injury		
Neurological (including Epilepsy and Alzheimer's disease)		
Deafblind (dual sensory)		
Vision – encompasses blindness and vision impairment (not corrected by glasses or contact lenses)		
Hearing – encompasses deafness, hearing impairment, hearing loss.		
Speech – encompasses speech loss, impairment and/or difficulty in being understood		
Psychosocial		
Other (please specify)		

### Reason for referral

Please identify the primary reason for referral

Please provide details

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### Support Needs

Please indicate how often the participant needs help or supervision with the following life areas or activities?

Please use Not Applicable where the need for help or supervision is due to the person's age.

	Always requires support	Sometimes requires support	Doesn't require support but uses equipment or aids	Doesn't require support nor equipment or aids	Not applicable
Self-care including washing, dressing, eating and toileting (Not applicable – under 5 years of age)					
Mobility					
Communication e.g. making self understood					
Interpersonal interactions and relationships					
Learning, applying knowledge and general tasks and demands (Not applicable – under 5 years of age)					
Education (not applicable – under 5 years of age)					
Community (civic) and economic life (not applicable under 5 years of age)					
Domestic Life (not applicable – under 15 years of age)					
Working (not applicable – under 15 years of age)					

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### Current Issues

Please indicate below which issues are impacting the participant.

	Never	Rarely	Sometimes	Very Often	Always
Accommodation/Homelessness					
Physical Health					
Mental Health/Emotional Wellbeing					
Family and/or relationship breakdown					
Domestic or family violence					
Child welfare concerns (e.g. abuse/neglect)					
Behavioural concerns (e.g. risk, antisocial behavior)					
Social isolation or lack of informal supports					
Limited life skills or orientation to services					
Financial hardship					
Legal issues					
Difficulty with accessing or continuity of current services					
Difficulty with accessing the NDIS					
Other (please specify)					
Other (please specify)					
Other (please specify)					

**Additional information regarding support required**

**Background and current circumstances**

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### PARENT OR LEGAL GUARDIAN DETAILS

**Name:**

Title:

Relationship to Participant:

First Name:

Last Name:

**Address:** Tick if same as Participant  or complete below  
Unit Number:

Street Number:

Street Name:

Street Type:

Suburb:

State:

Postcode:

**Contact Details:** Tick if same as Participant  or complete below

Telephone:

Email:

### REFERRER DETAILS

**Organisation:**

Name of Organisation:

**Address:**

Unit Number:

Street Number:

Street Name:

Street Type:

Suburb:

State:

Postcode:

**Contact Details:**

Referrer First Name:

Referrer Last Name:

Telephone:

Email:

**Service Information:**

Length of service with participant:

Services provided to participant:

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### Supports by other organisations or services:

Please provide contact details for any organisations or services involved supporting the participant, if known.

Organisation or Service Name	Key Worker (if applicable)	Phone Number:	Email address:

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### INFORMED CONSENT INFORMATION

#### Attachment A – Consent to provide, release and share information

This form is for participants who would like to access the Integrated Service Response Program and is about seeking agreement (called informed consent), for them to provide information and to release and share information about the participant and family.

As part of working with participants, the Community Services Directorate will ask personal information about their circumstances. **There are laws that protect how this information is used. It is very important for participants to know that we would not use any information without asking for their consent, except if we are required to do so under the law, or in exceptional cases to lessen or prevent a serious threat to life, health or safety of any individual, or to public health or safety.**

To make sure the participant receives the support that is needed, we may involve other services that are provided by the ACT Government or by community organisations. This may mean that we would share some information about the participant with other areas of the Community Services Directorate (e.g. Housing ACT; Child, Youth and Families, Office for Disability). We may also need to share some of the participant's information with other government agencies or community organisations that provide support.

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### ATTACHMENT A – CONSENT TO PROVIDE, RELEASE AND SHARE INFORMATION

Please ensure this form is signed by the Participant, Parent or Legal Guardian as applicable and the signed copy returned to the Community Services Directorate with application form.

#### Age:

Is the participant under 18 years of age?

No – go to Section 1A    No, but has a legal guardian – go to Section 1B    Yes – go to question 1B

#### Section 1A – Participant Consent

The consent (agreement) to provide, use and disclose your personal information:

Name	Signature	Date

#### Section 1B – Parent or Legal Guardian Consent

The consent (agreement) to provide, use and disclose information on behalf of an individual in which you are the legal guardian:

Name	Signature	Date
Signature on their behalf:		

#### Individuals, organisations or services to be excluded from Consent:

Please list below if there are any individuals, organisations or services the Participant wishes to exclude from consent (agreement) to provide, use and disclose information.

Organisation or Service Name	Key Worker (if applicable)	Phone Number:	Email address:



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### FURTHER INFORMATION

Please send your completed form to: [OfficeforDisability@act.gov.au](mailto:OfficeforDisability@act.gov.au)

If you require further information or have any questions, please contact the Office for Disability on (02) 6207 6315

### ACCESSIBILITY

The ACT Government is committed to making its information, services, events and venues, accessible to as many people as possible.

If you have difficulty reading a standard printed document and would like to receive this publication in an **alternative format** – such as large print or audio – please telephone **(02) 6207 6315..**

If English is not your first language and you require the **translating and interpreting services** – please telephone **131 450.**

If you are deaf or hearing impaired and require the **National Relay Service**, phone **133 677 then ask for 133 427**

### PRIVACY NOTICE

- The personal information you supply on this form will only be used for the purpose of processing your application. Your application must include an email or postal address to which the respondent can send notices under the Act. If all or some of this information is not collected, the Community Services Directorate may not be able to communicate with you, inhibiting their obligations under the Act. This could mean the request cannot be dealt with. Your personal information will not be disclosed to a third party without your consent unless statutory obligations require otherwise.
- The Community Services Directorate Privacy Policy contains information on how you can access or seek to correct any of your personal information that is held by the Directorate, as well as the process for lodging a complaint about an alleged breach of the *Information Privacy ACT 2014*. The Privacy Policy can be found on the Community Services Directorate website at [https://www.communityservices.act.gov.au/home/full\\_privacy\\_statement](https://www.communityservices.act.gov.au/home/full_privacy_statement).