

**Cera Care**

NDIS Registration ID: 4-L1MG9EW

ABN: 84 640 761 173

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NDIS Referral Form

1. Participant Details

Full Name: _____

Date of Birth: ____ / ____ / ____

NDIS Number (if available): _____

Address: _____

Phone: _____ Email: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Other: _____

2. Primary Contact (if different from participant)

Name: _____

Relationship to Participant: _____

Phone: _____ Email: _____

3. Referral Source Details

Referring Organisation: _____

Referrer Name: _____

Position: _____

Phone: _____ Email: _____

☐ Self-referral ☐ Family/Carer ☐ Support Coordinator ☐ Health Professional ☐ Other: _____

4. Participant Disability Information

Primary Disability: _____

Secondary Disability (if applicable): _____

Is the disability permanent? ☐ Yes ☐ No ☐ Unsure

Brief description of functional impact:

5. Services Requested

☐ Support Coordination

☐ Personal Care

☐ Community Participation

☐ Supported Independent Living (SIL)

☐ Allied Health

☐ Behaviour Support

☐ Other: _____

Additional Notes: _____

6. Risk & Safety Considerations

☐ Behavioural concerns

☐ Medical risks

☐ Mental health concerns

☐ Allergies

☐ Other: _____

Details: _____

7. Supporting Documentation Attached

■ NDIS Plan

■ Medical Reports

■ Functional Assessment

■ Behaviour Support Plan

■ Other: _____

8. Consent

I confirm that the participant (or authorised representative) has consented to this referral and the sharing of relevant information in accordance with privacy legislation.

Participant / Representative Name: _____

Signature: _____ Date: ____ / ____ / ____

9. For Office Use Only

Date Received: ____ / ____ / ____

Staff Member: _____

Outcome: ■ Accepted ■ Waitlisted ■ Declined

Notes: _____
