



Applicant/ Participant details	
Full Name:	
Date of Birth:	
Phone:	
Email:	
Current Address:	
Postal Address:	
Cultural Identity	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Other _____
Primary Language Spoken:	
Alternative contact person	
(Someone the applicant would like to be contacted to support them with the access process e.g, Carer, family member, partner)	
Full name:	
Phone:	
Relationship to the applicant:	

Child Representative / Legal Guardian	
Please tick the appropriate box: if required	<input type="checkbox"/> Person with Parental responsibility (If under 18) <input type="checkbox"/> Legal Guardian (Court appointed)
Full Name:	
Phone:	
Email:	
Address:	

Clinic to be referred to:	<input type="checkbox"/> BRAMS <input type="checkbox"/> DAHS <input type="checkbox"/> OVAHS <input type="checkbox"/> YYMS <input type="checkbox"/> KAMS
---------------------------	---

CONSENT TO EXCHANGE INFORMATION

Do you consent to the Referrer talking to the AMS clinic; giving them information about you and getting information about you from them in regards to the NDIS access process

- Yes, I consent or
 No, I do not consent. I will provide the information myself

 Applicant signature:
 Or if required, Parent (under 18) / Legal Guardian

 Date:



Functional impact:

Please tick the relevant substantially reduced functional capacity / impairment / struggles / difficulties

<input type="checkbox"/>	Mobility / Motor Skills – e.g. move & get around in your home/ community, getting in & out of bed/chair, requires aids or equipment such as wheelchair, crutches, walking stick, gofer, visually impaired stick etc.
<input type="checkbox"/>	Communication – e.g. talking, following conversations or directions, requires hearing aids or communication equipment
<input type="checkbox"/>	Social Interaction – e.g. join in with other people, make friends and be part of the community
<input type="checkbox"/>	Learning – e.g. understand things, concentrating, remembering
<input type="checkbox"/>	Self–Care – e.g. look after themselves, showering, getting dressed, eating, toileting, taking medication
<input type="checkbox"/>	Self–Management – e.g. managing responsibilities, making decisions, budgeting money, making and attending appointments, obtaining and keeping a job, assistance with shopping and cleaning

Comments:

Referrer’s Name:	
Referrer’s organisation/ relationship to the applicant :	
Referrer’s Contact Details:	