Please complete this Request for Service form with as much information as possible.

Better Lives Support Services know how valuable your time is and that is why we have developed this process to capture information in a timely manner.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Request:** | Click or tap here to enter text. | **NDIS #** | Click or tap here to enter text. |
| **Full Name** | Click or tap here to enter text. |
| **Residential Address** | Click or tap here to enter text. |
| **Postal Address** | Click or tap here to enter text. |
| **Date of Birth** | Click or tap here to enter text. | **Age** | Click or tap here to enter text. |
| **Phone #** | Click or tap here to enter text. | **Mobile #** | Click or tap here to enter text. |
| **Email Address** | Click or tap here to enter text. |
| ***Please indicate any restrictions or safety issues in calling you or sending emails to this information*** |
| Click or tap here to enter text. |
|  |
| **Diagnosis***& any other relevant information* | Click or tap here to enter text.  |
| **Is there a current Behaviour Support Plan in Place?** *Please provide details if restrictive interventions are part of plan.* | Click or tap here to enter text. |
| **Who referred you / How did you find us?** | Click or tap here to enter text. |
|  |
| **Plan Manager / Managing Organisation - for supports requesting** |
| **Organisation** Click or tap here to enter text.**Contact Person** Click or tap here to enter text.**Contact Details** Click or tap here to enter text. |
| **Support Coordinator**  |
| **Organisation** Click or tap here to enter text.**Name** Click or tap here to enter text.**Contact Details** Click or tap here to enter text. |

**RISK ASSERSSMENT Completed by:**Click or tap here to enter text.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **COMMUNICATION** | **Yes** | **No** |  | **COGNITION** | **Yes** | **No** |
| Hearing Ok | [ ]  | [ ]  |  | Client willing to participate and assist in care | [ ]  | [ ]  |
| Speech Ok | [ ]  | [ ]  |  | Oriented in time and place | [ ]  | [ ]  |
| Able to write | [ ]  | [ ]  |  | Client able to accept direction and instruction | [ ]  | [ ]  |
| English language skills | [ ]  | [ ]  |  | Short-term memory issues | [ ]  | [ ]  |
| **Further Comments:** |  | **Further Comments:** |
| Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MOBILITY & MANUAL HANDLING** | **Yes** | **No** |  | **PERSONAL CARE ASSISTANCE REQUIRED** | **Yes** | **No** |
| Walk unaided | [ ]  | [ ]  |  | Showering / Toileting | [ ]  | [ ]  |
| Manages stairs unaided | [ ]  | [ ]  |  | Grooming | [ ]  | [ ]  |
| Uses walking aid to walk | [ ]  | [ ]  |  | Eating | [ ]  | [ ]  |
| Uses wheelchair | [ ]  | [ ]  |  | Mouthcare | [ ]  | [ ]  |
| Is manual handling equipment in place and used | [ ]  | [ ]  |  | Skin care | [ ]  | [ ]  |
| **Further Comments:** |  | **Further Comments:** |
| Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **AGGRESSION / VIOLENCE** | **Yes** | **No** |
|  *H=History of C=Current Risk*  |
| Physical aggression to support worker | **H C****[ ]** **[ ]**  | **[ ]**  |
| Verbal aggression to support worker | **H C****[ ]  [ ]**  | **[ ]**  |
| Aggression to other clients | **H C****[ ]  [ ]**  | **[ ]**  |
| Aggression with/against objects | **H C****[ ]  [ ]**  | **[ ]**  |
| Self-harm | **H C****[ ]  [ ]**  | **[ ]**  |
| Substance abuse | **H C****[ ]  [ ]**  | **[ ]**  |
| Sexual abuse | **H C****[ ]  [ ]**  | **[ ]**  |
| Threats to staff in any way | **H C****[ ]  [ ]**  | **[ ]**  |
| Use of emotions to achieve goals | **H C****[ ]  [ ]**  | **[ ]**  |
| **Further Comments:** |
| Click or tap here to enter text. |

|  |
| --- |
| **Brief outline of Supports Requesting: (e.g. Medications, Cleaning, Socialising etc.)** |
| Click or tap here to enter text. |
|  |
| **NDIS Support Code(s) *(Relevant to participants NDIS Plan for supports requesting):*** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
|  |
| **Details for services Hours / Times required** | **Days of the week required** |
| **Morning Times** | Click or tap here to enter text. | **[ ] Mon [ ] Fri****[ ] Tue [ ] Sat****[ ] Wed [ ] Sun****[ ] Thu [ ] P/H’s** |
| **Afternoon Times** | Click or tap here to enter text. |
| **Night Times** | Click or tap here to enter text. |
| **24/7 Care** | **[ ]**  |
| **Total Days** |  per [ ] **Week** [ ] **Fortnight** [ ] **Month** |
| [ ] Until end of plan **Date:** Click or tap here to enter text. | [ ] Until specific date**Date:** Click or tap here to enter text. |
| **Any other relevant information?** |
| Click or tap here to enter text. |

Thank you for your referral.

**Please return the referral form to:** contact@blss.net.au

**Once returned we will make every effort to contact you as soon as possible.**

**Kind Regards,**

**Better Lives Support Services**