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**Support Work Service Request**

**Please attach risk assessment and NDIS Plan**

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| **REFERRER INFORMATION** | | | |
| **Referrer Name** |  | **Phone** |  |
| **Organization** |  | **Email** |  |
| **Role** |  | **Date of referral** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PARTICIPANT INFORMATION** | | | | | |
| **First Name** |  | **Last Name** | |  | |
| **Date of Birth** |  | **NDIS Number** | |  | |
| **Plan Start Date** |  | **Plan End Date** | |  | |
| **Address Line 1** |  | **Mobile** | |  | |
| **Address Line 2** |  | **Home Phone** | |  | |
| **Email** |  | **Interpreter Required** | | *Yes / No* | *Language Req’d* |
| **Mental Health Concerns** |  | | | | |
| **Medical Issues** |  | | | | |
| **Type of Support Requested** |  | | | | |
| **Support Preferences** | *Male / Female / No Preference* | | *Hobbies / Interests* | | |
| *Hours of Support per week* | | *Age Preference* | | |

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| **PLAN MANAGEMENT INFORMATION** | | | |
| **Plan Manager** |  | **PHONE** |  |
| **ORGANISATION** |  | **EMAIL** |  |