Please note\* *We cannot take on every client who is referred straight away, we match clients with support workers and grow our team/clients slowly to maintain high standards of care. All new referrals will be contacted within 7 days to discuss their needs and determine the best possible match. Our priority is ensuring quality over quantity, so every client receives the dedicated and personalized support they deserve.*

**Client Details**

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Gender | Male Female Other |
| Date of Birth |  |
| Phone Number |  |
| Email Address |  |
| Street Address |  |

**Current main support or support coordinator**

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Agency |  |
| Phone Number |  |
| Email Address |  |

**NDIS Details**

|  |  |
| --- | --- |
| Plan | Plan Managed Self Managed Agency Managed |
| NDIS Number |  |
| Do you have a copy of your plan? |  |
| Are you able to share your plan with us via email? |  |
| Plan Start Date |  |
| Plan Review Date |  |

**Referrer Details** (Person Making the Referral)

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Agency |  |
| Phone Number |  |
| Email Address |  |

I have obtained consent from the participant to make this referral and provide TailoredCare with the participant's personal and medical details.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

File Upload (Please attach a copy of the current NDIS plan if possible)

**Completed forms should be saved and emailed to – tailoredcarebme@gmail.com**