SUPPORT COORDINATION REFERRAL FORM

Referral Date: _____ Referral Managed By: _____

Client Details			
Surname			
First Name			
DOB:			
NDIS number:			
Guardian or Nominee Details (if applicable)			
Surname			
First Name			
Contact Details (please indicate preferred contact method)			
Home Phone		**Mobile Phone**	
Work Phone			
Email Address			
Address			

NDIS Plan Details	
Plan Dates (start and end)	
SC funding level (2 or 3)	
Hours funded in current plan	
SC budget remaining in current plan	
SC staff preference if any (profiles on website)	

REFERRAL FORM

Referrer Details (if not client or guardian/nominee)			
Name		**Position**	
Organisation		**Contact Details**	
Referrer Reason			
Further Client Details			
Preferred Language		**Pronouns**	
Aboriginal or Torres Strait Islander?		**Yes ☐ No ☐**	
Interpreter Required?		**Yes ☐ No ☐**	
Other Support Required			

Action Taken / Follow Up

Client/Guardian Declaration			
I consent to my information being provided to Tibii for the purposes of referral, service delivery and inclusion in de-identified data reporting.			
Full Name		Date	
Signature of Client/Guardian			

Please return to Support Coordination Department Manager
emmaf@tibii.com.au, 0432464333

www.tibii.com.au/team-5

Location of client and any preferences for staff will be considered. We will contact you via your preferred method indicated above within 48 business hours of receiving this referral.

We recommend an initial face to face meeting to explore if Tibii SC Services are a good fit for your needs (not billed). This is not necessary if the client so chooses, and client choice and preference will always be respected. This is offered as best practice in line with our person-centered values and use of the Human Rights Model of Disability.
We look forward to exploring the possibility of working together.