

REFERRAL FORM FOR HOSPITALS, LHDs & CLINICIANS

For hospitals, community mental health services, outpatient clinics, GPs, specialists, allied health professionals and other health or clinical services.

We aim to respond within 1–2 business days. Please complete the sections relevant to this referral and provide only information needed to assess and safely deliver the requested disability supports.

Important: My ResponsAbility is not an emergency, acute mental health or crisis-response service. If there is an immediate risk to someone's safety, contact 000 or the person's current treating or crisis team.

1. Referrer details

Referrer name *	Role / profession *
Organisation *	Team, clinic, ward or service
Phone *	Email *
Preferred contact method	Best contact times

Referring service type

- | | |
|---|--|
| ☐ Inpatient hospital or mental health unit | ☐ Community mental health service |
| ☐ Hospital outpatient clinic | ☐ GP or medical specialist |
| ☐ Allied health service | ☐ Other health or community service |

2. Participant details

Participant full name *	Preferred name
Date of birth *	NDIS number (if known)
Participant phone	Participant email (if known)
Preferred language	Interpreter required
Important communication or decision-support needs <i>For example: preferred communication method, interpreter, communication aid, supported decision-making or accessibility needs.</i>	

Current living situation

- | | |
|--|---|
| ☐ Living at home | ☐ In hospital or an inpatient unit |
| ☐ Temporary accommodation | ☐ Accommodation being arranged |
| ☐ No fixed address | ☐ Other |

Usual address or suburb (if known)	Current location (if different)
Expected address after discharge or transition (if known)	Postcode (if known)

3. Consent and first contact

Is the participant aware of this referral?

- ☐ Yes ☐ No ☐ Unsure

Has the participant consented to My ResponsAbility receiving this referral and contacting the nominated person?

- ☐ Yes ☐ Consent is being confirmed
☐ No ☐ Unable to confirm

Where consent has not been confirmed, provide only the minimum information needed for initial contact. Do not attach detailed clinical or health records unless there is an appropriate lawful basis for doing so.

Who should My ResponsAbility contact first about this referral?

- ☐ Participant ☐ Referrer
☐ Representative, nominee, family member or support person ☐ Support Coordinator or Recovery Coach
☐ Other

Nominated contact name *	Role / relationship to participant
Phone *	Email
Preferred contact method	Best contact times

4. Support requested

What support is being requested? Select all that apply.

- ☐ Psychosocial Recovery Coaching ☐ Support Coordination
☐ Community Access, Daily Living & Transport ☐ Hospital-to-Community Transition Support
☐ Accommodation, Tenancy & Life Transitions ☐ Employment, Education & Community Participation
☐ Unsure – please discuss the options ☐ Other

If other, please specify

Expressions of interest

- ☐ Group activities or programs ☐ Supported Independent Living or shared living arrangements

Expressions of interest relate to possible future service availability and do not guarantee that My ResponsAbility can offer or commence the service.

What has prompted the referral? *

What does the participant want help with? *

Relevant NDIS plan goals (if known)

Approximate support frequency or hours (if known)

Preferred commencement date

Preferred days / times (if known)

Preferred support location (if known)

Is this referral time-sensitive?

- ☐ No ☐ Yes

If yes, provide the date or deadline and why the referral is time-sensitive

5. NDIS plan and funding information

Current NDIS plan status

- ☐ Current plan
 ☐ Plan pending
- ☐ No current plan
 ☐ Unsure

Plan start date (if known)

Plan end / reassessment date (if known)

Funding management

- ☐ NDIA-managed
 ☐ Plan-managed
- ☐ Self-managed
 ☐ Unsure

Is funding believed to be available for the requested support?

- ☐ Yes
 ☐ No
- ☐ To be confirmed
 ☐ Unsure

Plan manager name / organisation (if applicable)

Plan manager phone / email

Support Coordinator / Recovery Coach (if applicable)

Phone / email

6. Essential support and safety information

Is there anything My ResponsAbility needs to know before contacting, meeting or supporting the participant? *

Include only relevant information about communication, mobility, falls or manual handling, allergies or swallowing, health considerations relevant to support, known triggers and helpful strategies, significant safety or safeguarding risks, home or community risks, or essential worker-matching requirements.

Does the participant require medication-related support from disability workers?

- ☐ No
 ☐ Reminders or prompting only
- ☐ Assistance with self-administration
 ☐ Administration or more complex medication support
- ☐ Unsure

Any medication-related support will be assessed before acceptance and must be within My ResponsAbility's service scope, supported by appropriate instructions and delivered by a competent worker.

Does the participant have a current Behaviour Support Plan?

- ☐ Yes
 ☐ No
 ☐ Unsure

Are any regulated restrictive practices currently used or authorised?

- ☐ Yes
 ☐ No
 ☐ Unsure



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Is a current risk or safety plan available?

- ☐ Yes – attached ☐ Yes – to follow
☐ No ☐ Unsure

7. Hospital discharge or transition details *Complete only if relevant*

Is this referral connected to a hospital discharge or transition?

- ☐ No ☐ Yes

Hospital / facility	Ward / unit
Expected discharge or transition date	Proposed destination

Is the proposed accommodation or destination confirmed?

- ☐ Yes ☐ No
☐ Not applicable ☐ Unsure

What support is required immediately after discharge or transition?

Is any equipment, clinical plan, worker training or other preparation required before support can begin?

Discharge / transition coordinator	Phone / email
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Can My ResponsAbility attend a discharge or transition meeting?

- ☐ Yes ☐ No ☐ To be discussed

8. Relevant attachments

Please provide only documents relevant to assessing or safely delivering the requested disability supports. Do not attach complete clinical records unless necessary.

☐ Attached ☐ To follow Relevant NDIS plan pages or goals	☐ Attached ☐ To follow Brief clinical, functional or psychosocial summary
☐ Attached ☐ To follow Discharge or transition summary	☐ Attached ☐ To follow Current risk or safety plan
☐ Attached ☐ To follow Behaviour Support Plan and relevant authorisation information	☐ Attached ☐ To follow Medication instructions relevant to disability-worker duties
☐ Attached ☐ To follow Mealtime management, manual handling or communication plan	☐ Attached ☐ To follow Guardianship, nominee or decision-making documentation
☐ Attached ☐ To follow Relevant allied health recommendations	☐ Attached ☐ To follow Other
Other attachment details	



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9. Referrer declaration and submission

☐ I confirm that, to the best of my knowledge, the information provided is accurate and relevant to this referral, and that the participant's consent status and contact preferences have been recorded accurately.

Referrer name *	Position / role *	Date *
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Submit this completed form and relevant attachments to: Referrals@MyResponsAbility.com.au

Questions or assistance: 02 7205 4859 | Monday to Friday 9:00 am–5:00 pm; weekends 10:00 am–2:00 pm

Privacy collection notice

My ResponsAbility collects the information in this form to assess the referral, contact the nominated person, determine service fit and capacity, and plan safe supports if the referral proceeds. Information will be handled in accordance with our Privacy Policy and may be stored in the participant's My ResponsAbility record where appropriate. For privacy enquiries, contact Service@MyResponsAbility.com.au.

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