**Referral Form**

**Referrals to be made with the consent of the**

**Participant, including their Nominee or Legal Guardian**

Leah Bett Nursing Services

6/64 Todd Mall

Alice Springs

Mobile No 0401552921

ABN NO 46639984704

NDIS Provider Number 4050019739

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

|  |  |
| --- | --- |
| DATE |  |

|  |
| --- |
| Where did you hear about Leah Bett Nursing Services? |
|  |

|  |
| --- |
| Details of Person Requiring Support |
| Title | [ ]  Mr [ ]  Mrs [ ]  Ms [ ]  Miss [ ]  Other (Please specify) |
| First Name |  | Surname |  |
| Date of Birth |  |
| Gender |  [ ]  Male [ ]  Female [ ]  Other (Please specify) |
| NDIS No. |  |
| Residential Address |  |
| Phone Number |  |
| Email ID |  |
| Identifies as | [ ]  Aboriginal [ ]  Torres Strait Islander[ ]  Aboriginal and Torres Strait Islander [ ]  Neither |
| Plan Start Date |  | Plan End Date |  |
| [ ]  Self-Managed [ ]  Plan Managed [ ]  NDIS Manage |
|  |
| If Plan Managed, please provide the details of the plan manager: |
| Company Name |  |
| Contact Person Name |  |
| Phone Number |  |
| Email |  |
|  |  |
| Emergency contact / next of kin (if available) |
| Name |  |
| Relationship |  |
| Phone Number |  |
| Email |  |

|  |
| --- |
| Nominee/Guardian (if Applicable) |
| Name |  |
| Address |  |
| Phone Number |  |
| Email |  |
| Relationship |  |

##  Is the person requiring support…

|  |  |
| --- | --- |
| [ ]  | An adult living in supported accommodation or in supported independent living(any dogs, hazards, or risk we should be aware of?) |
|[ ]  A child or young person living in foster care or residential care or with parents? |
|[ ]  Other – please specify. |

##  How many hours are required for the requested services?

|  |  |  |
| --- | --- | --- |
|  | Hours per week | Supports Required |
|  |  |  |
|  |

 **CURRENT SUPPORTS – please specify below any current/ongoing support and/or support staff**

 **who can assist in providing relevant history of day-to-day activities?**

What specific support is required?

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | Diabetes Management  | [ ]  | Pressure area care/assessment and wound care |
|[ ]  Subcutaneous injections (e.g., insulins) |[ ]  Staff Training on how to perform blood sugars, recording how to respond to hypoglycemia and hyperglycemia episodes |
|[ ]  Enteral feeding and management. |[ ]  Administration of laxatives, enemas, and suppositories as prescribed by the doctors |
|[ ]  Medication administration and management. |[ ]  Administration of non-routine medication as required |
|[ ]  Blood sugar monitoring and recordings |  |  |
|[ ]  Continence Assessment |  |  |
|[ ]  Assist personal activities |  |  |
|[ ]  Participation in Community, Social, and Civic (0125) |  |  |
|[ ]  Household Tasks |  |  |
|[ ]  Respite (STA) |  |  |
|[ ]  Any other nursing supports or service that may be required |

## Please briefly describe the participant’s status (if bed restricted, wheelchair etc.)



 Please tick all that apply

|  |
| --- |
|[ ]  Intellectual disability |
|[ ]  Physical disability |
|[ ]  Neurological disability |
|[ ]  Psychosocial/mental health disability |
|[ ]  Medical Conditions on board |

## Please provide any additional information regarding the clinical nursing support needed



|  |
| --- |
| Name of Person Making this Referral  |
| Company Name (if applicable) |  |
| Contact Person Name |  |
| Phone Number |  |
| Email |  |

Date of referral: …./…./….

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for your referral.**

Leah Bett.

Clinical Nurse Consultant (B.Sc. in nursing, M.Sc. in health sciences, M.Sc. in public health and Diploma in Clinical Management and Leadership)

Community nursing care.