**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.