Territory Community Services

PATHWAYS PROGRAM REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Other names: (if applicable)		Gender:	Male Female
Residential address:			
Postal address: (if different)			
Contact numbers:	Home: Mobile:		
Does the Participant identify as:	Aboriginal Torres Strait Islander Neither		
Has the Participant consented to this referral?	Yes No		
Primary diagnosis / disability: (please attach supporting documentation)			
Secondary disability(ies) or other presenting issues:			
Communication status: (eg. verbal, sign etc)			
Personal mobility aids:			
Mobility aids required:	Hoisting Commode Sarah Steady Any other Assistive Devices _____		
Does Participant have challenging behaviours?			
Does participant have a current Behaviour Support Plan (PBSP)?	Yes Dated _____ (please provide a copy) → Has a PBSP review been requested: Yes No No → Is a PBSP required: Yes No		

SECTION 2: PATHWAYS PROGRAM ATTENDANCE

Please provide a copy of participant's goals from their NDIS Plan prior to commencement.

Please select requested days to attend:			Please select program:	Comments:
Monday	AM	PM		
Tuesday	AM	PM		
Wednesday	AM	PM		
Thursday	AM	PM		
Friday	AM	PM		

For specific program information, please go to our website - tcsnt.org.au

SECTION 3: TRANSPORT REQUIREMENTS

Please select below:

Monday		Tuesday		Wednesday		Thursday		Friday	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

SECTION 4: NDIS PLAN

NDIS Plan approved:	Yes	Pending (waiting NDIS response)	Not commenced	Not applicable

NDIS number:		Plan start date:		Plan end date:	

NDIS COS Details

Name:		Organisation:	
Email:		Phone:	

Plan Management:	Agency managed	Plan managed	Self-managed

If Plan Managed, contact details of Plan Manager:

Name:		Organisation:	
Email:		Phone:	

SECTION 5: CONTACT DETAILS			
Participant / Parent / Guardian:			
Address:		Contact numbers:	H: M:
Email:			
Signature:		Date:	

SECTION 6: REFERRER DETAILS			
Relationship to client:	Guardian (completed above, no further details required) Coordinator of Supports (complete referrer details)		
Organisation:		Contact numbers:	B: M:
Name:			
Postal address:			
Email:			
Signature:		Date:	

Please send the completed referral form to *Operations.tcsnt@gmail.com*
For additional enquiries regarding this referral, please phone the Intake Officer on +61 43087 9936

Completing this form is not a guarantee that the service can be provided. Territory Community Services requires completion of a service agreement for all services provided