



## Referral Form – Disability Services Local Coordination

People who live in an area where the WA National Disability Scheme (NDIS) does not yet operate may be eligible for Local Coordination support in the meantime.

Personal details of person being referred			
Full name			Date of birth
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans/Intersex/Another identity/undisclosed		
Address			
Postal Address			
Phone	H:	M:	Email:
Preferred language/dialect			Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
I give permission for this referral and understand that I will be contacted by a Local Coordinator			
Full name (print)			(or primary carer/next of kin/Guardian)
Signature			Date:

Primary carer/next of kin/Guardian details (if required)			
Full name			Relationship to person
Postal Address			
Phone	H:	M:	Email:

Disability (tick one or more if known)			
Autism	<input type="checkbox"/>	Neurological	<input type="checkbox"/>
Intellectual Disability	<input type="checkbox"/>	Physical	<input type="checkbox"/>
Sensory (e.g. vision and hearing)	<input type="checkbox"/>	Development delay	<input type="checkbox"/>
Cognitive/Acquired brain injury	<input type="checkbox"/>		
NOTE: Documents to support disability diagnosis and functional impact will be required in order for eligibility to be determined. Please make these available to the person that you are referring on request.			

Referrer details			
Full name			Organisation
Position title			Postal Address
Phone			Email
Signature			Date

Please submit this form to the person’s Local Coordination office.  
 Alternatively, you can email this form to [Admin\\_LC@dsc.wa.gov.au](mailto:Admin_LC@dsc.wa.gov.au) or post it to:  
 Local Operations, PO Box 441, West Perth WA 6872