Referral Form – Disability Services Local Coordination

People who live in an area where the 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	☐ Male ☐ Female ☐ Trans/Intersex/Another identity/undisclosed				
Address					
Postal Address					
Phone	H:	M:	Email:		
Preferred language/dialect			Interpreter required?	☐ Yes ☐ 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	☐	Neurological	☐
Intellectual Disability	☐	Physical	☐
Sensory (e.g. vision and hearing)	☐	Development delay	☐
Cognitive/Acquired brain injury	☐		
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 or post it to:
Local Operations, PO Box 441, West Perth WA 6872