Referral to early childhood partners

Please use this form when seeking support through the National Disability Insurance Scheme (NDIS) for a child who lives in **Inner Eastern Melbourne (Boroondara, Manningham, Monash, Whitehorse), Outer Eastern Melbourne (Knox, Maroondah, Yarra Ranges), Southern Melbourne (Cardinia, Casey, Greater Dandenong), Inner Gippsland (Bass Coast, Baw Baw, Latrobe, South Gippsland) or Outer Gippsland (East Gippsland, Wellington)** to record information about a child younger than 6, when there are concerns with their development, or a child younger than 9 with a disability.

# What is the early childhood approach?

The National Disability Insurance Scheme (NDIS) early childhood approach is a family-centred, holistic, and best practice approach to early intervention for children younger than 9 with disability or children younger than 6 with developmental delay or concerns. This approach is designed to provide children and their families with the support they need to achieve their goals and reach their full potential. If you believe a child younger than 9 may benefit from this support, you can make a referral.

# The early childhood partner’s role

Early childhood partners are a contact point for families and carers of children younger than 9, seeking support through the NDIS. They help to determine the most appropriate supports for the child and family, tailored to their individual needs and circumstances.

The types of supports provided by an early childhood partner may include connections:

* with mainstream and community services
* to practical information relevant to a child’s development
* with other families
* with early supports
* to apply to the NDIS

# How to complete and submit this form

This form may be completed by:

* a family or carer, with the assistance of a professional
* a professional working with the family or carer such as a GP or paediatrician

There are three steps to complete and lodge this form**:**

1. Complete the referral to early childhood partner form and record parent, carer, guardian or child representative consent.
2. If consent is provided by the parent, carer, guardian or child representative, please attach copies of any relevant assessments, reports or letters from health professionals that describe the child’s needs in support of this information form where appropriate.
3. Return the completed information form and any attachments to:
* Email: ECEI.LINK.LCHS@ndis.gov.au
* Mail: Shop 1, 607 Canterbury Road, Vermont VIC 3133
* In person: You may bring this form to the following office locations:
* Suite 1, 7 Bakewell Street, Cranbourne VIC 3977
	+ - * + 2 Euneva Avenue, Glen Waverley VIC 3150
				+ Level 2, 26-28 Prospect Street, Box Hill VIC 3128
				+ Shop 1/607 Canterbury Road, Vermont VIC 3133
				+ Level 1, 88 Maroondah Highway, Ringwood VIC 3134
				+ 1st Floor, 7 Post Office Place, Traralgon VIC 3844
				+ 68 Macleod Street, Bairnsdale VIC 3875

# Do you need more information?

* Online: Further information can be found at the NDIS website ([ndis.gov.au](http://www.ndis.gov.au))
* Phone: 1800 546 532

# Referral to early childhood partners

## Child’s details

| Child’s details required | Please complete all sections below |
| --- | --- |
| Child’s full name: |  |
| Date of Birth DD/MM/YYYY: |   |
| Aboriginal or Torres Strait Islander?  |  |
| Country of birth: |  |
| Is the child either: | Australian Citizen |[ ]
|  | Permanent Resident |[ ]
| **If No, does the child hold:** | Protected Special Category Visa holder: [ ]  Yes [ ]  NoOther type of visa? Please specify:  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number: \_\_\_\_\_\_\_\_\_\_\_ |
| Centrelink Reference Number (CRN): |  |
| Who does the child live with? |  |
| Home address: |  |

|  |  |
| --- | --- |
| Are there any other family members NDIS participants? | [ ]  Yes [ ]  No |
| If YES, provide details:  | Name:  | NDIS Reference Number: |
|  |  |
|  |  |
|  |  |

## Family or carer details

| Family or carer 1 details | Please complete all sections below |
| --- | --- |
| Family or carer 1 full name: |  |
| Date of Birth DD/MM/YYYY: |  |
| Relationship to child? |  |
| Aboriginal or Torres Strait Islander? |  |
| Home address: |  |
| Contact number: |  |
| Email: |  |
| Preferred contact method: |  |
| Preferred language: |  |
| Country of birth: |  |
| Is the adult either: | Australian Citizen | ☐ |
| Permanent Resident | ☐ |
| If No, does the adult hold:  | Protected Special Category Visa holder:  ☐ Yes ☐ NoOther type of visa? Please specify:  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number: \_\_\_\_\_\_\_\_\_\_\_ |
| Centrelink Reference Number (CRN): |  |

|  |  |
| --- | --- |
| Family or carer 2 details | Please complete all sections below |
| Family or carer 2 full name: |  |
| Date of Birth DD/MM/YYYY: |  |
| Relationship to child? |  |
| Aboriginal or Torres Strait Islander? |  |
| Home address: |  |
| Contact number: |  |
| Email: |  |
| Preferred contact method: |  |
| Preferred language: |  |
| Country of birth: |  |
| Is the adult either: | Australian Citizen | ☐ |
| Permanent Resident | ☐ |
| If No, does the adult hold:  | Protected Special Category Visa holder:  ☐ Yes ☐ NoOther type of visa? Please specify:  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number: \_\_\_\_\_\_\_\_\_\_\_ |
| Centrelink Reference Number (CRN): |  |

## Additional details

| Documentation details | Please complete all sections below |
| --- | --- |
| Custody or court ordersIs there an existing parenting, custody or guardianship arrangement for the child?If ‘yes’ please attach when submitting this form. |  |
| Has your child had any assessments or diagnoses?If yes, please provide details or attach reports. |  |
| Is your child undergoing assessment for developmental delay or disability? | Yes |[ ]
|  | No |[ ]
| Additional information (for example: recent hospitalisation, starting school soon, etc.) |  |

## Other services in place or previously accessed

| Service 1 details | Please complete all sections below |
| --- | --- |
| Name**:** |  |
| Profession**:** |  |
| Contact details(including organisation name): |  |
| Consent**:**Does the parent, carer or guardian give permission for us, the early childhood partner, to contact the above listed professional or service provider and share the child’s information to better understand their circumstances? | Yes |[ ]
|  | No |[ ]

| Service 2 details | Please complete all sections below |
| --- | --- |
| Name**:** |  |
| Profession**:** |  |
| Contact details(including organisation name): |  |
| Consent**:**Does the parent or carer or guardian or give permission for us, Link Health and Community, to contact the above listed professional or service provider and share the child’s information to better understand their circumstances? | Yes |[ ]
|  | No |[ ]

## Current concerns in areas of major life activity

| Areas of major life activity | Provide details below orattach any relevant reports. |
| --- | --- |
| Self-Care**:**For example, how they bathe, dress themselves, eat, drink, use the toilet and sleep. |  |
| Receptive and Expressive Language**:**For example, how they understand words (including through gestures and signs) and how they communicate with you (i.e. through facial expressions, gestures or verbal words). |  |
| **Cognitive Development:**For example, how they understand and remember information, learn new things, practice and use new skills, play with others, develop social and safety skills and problem solve. |  |
| Motor Development**:** For example, how they move around their home and community (such as walking, running and crawling). It could also include information about how they use their hands to pick up and play with different objects. |  |

# Referrer details

Note**:** Please only complete this section if the referrer is from an organisation.

If you are a **p**arent, carer or guardian of the child, please go to [parent or carer](#_Parent_/_Carer) consent section on the next page.

| Referrer details | Please complete all sections below |
| --- | --- |
| Date DD/MM/YYYY: |  |
| Organisation making referral: |  |
| Contact person: |  |
| Phone number: |  |
| Email address: |  |
| Office address: |  |

Note**:** The early childhood partner may need to contact the professional listed above to better understand the child’s circumstances and to ensure that the child is connected to the supports that best meets their needs.

|  |
| --- |
| Consent to contact the professional referrer is provided |
| Yes |[ ]
| No |[ ]

#

# Parent or carer consent

|  |
| --- |
| By signing this form |
| * I have read and understood the General Information and the Important Privacy Information provided with this information form.
 |[ ]
| * I understand how my child’s personal information will be collected, used and disclosed for the purposes of the NDIS, which is set out below in Privacy Policy.
 |[ ]
| * I have carefully read all of the information provided in the referral form and confirm that it is accurate, complete and up to date.
 |[ ]
| * I consent to Link Health and Community collecting, using and disclosing personal and sensitive information about my child in accordance with the General Information and Important Privacy Information sections in this document.
 |[ ]
| * I understand that I may withdraw consent to receive support from an early childhood partner at any time.
 |[ ]
| * I give permission to contact the professional completing or assisting with this information form (if any).
 |[ ]

Please complete your details on the next page**.**

|  |
| --- |
| Parent or carer’s details |
| Signature: |  |
| Name: |  |
| Please tick your relationship to the child: | Parent | [ ]  |
| Carer | [ ]  |
| Guardian | [ ]  |
| **Professional referring child (if relevant)** | If relevant, please confirm that you have received verbal consent from the child’s parent, carer or guardian to make this referral | Consent:[ ]  |
| Date: DD/MM/YYYY |  |

# Privacy Policy

<https://www.lchs.com.au/privacy>