AMAZE ConnectCare

Phone: 0422 382 222
Email: info@amazecc.com.au

Amaze ConnectCare – Referral Form

Participant Details

First Name *: _____

Last Name *: _____

Date of Birth *: ____ / ____ / ______

Ensure the participant's age is at least 7 years. Forms submitted with an invalid age will be rejected.

Gender: ☐ Male ☐ Female ☐ Other

Street Address: _____

Suburb *: _____

State: VIC (Amaze ConnectCare currently operates only in Victoria)

Postcode *: _____

Phone Number: _____

Email Address *: _____

Preferred Language: _____

Cultural Background: _____

Interpreter Required: ☐ Yes ☐ No

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NDIS Details

Primary Disability: _____

Plan Management Type *: ☐ Plan Managed ☐ Self Managed ☐ Other

Important: NDIA-Managed plans are currently not supported by Amaze ConnectCare.

NDIS Number (Optional): _____

Plan Start Date: ____ / ____ / ______

Plan Review Date: ____ / ____ / ______

Reason for Referral & Service

Support Services Required (select all that apply) *:

☐ Therapeutic Supports
☐ Personal Support & Daily Tasks
☐ Community Participation & Skill Building
☐ Community Nursing Care
☐ Assistive Technology & Communication
☐ Home Modifications
☐ Other (please specify below)

If Other, please specify: _____

Weekly Services Required (Select days and include hours per day):

☐ Monday – Hours: _____
☐ Tuesday – Hours: _____
☐ Wednesday – Hours: _____
☐ Thursday – Hours: _____
☐ Friday – Hours: _____
☐ Saturday – Hours: _____
☐ Sunday – Hours: _____

Additional Notes: _____

Email any supporting documents along with this form.

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Referrer Identity

Are you the participant completing this referral? *:

☐ Yes ☐ No

Only complete the below "Referrer Details" section if you are NOT the participant and have selected "No" to the above question.

Referrer Details

Referrer's Name *: _____

Referrer's Organisation (If applicable): _____

Referrer's Phone Number *: _____

Referrer's Email *: _____

Preferred Contact Person *:

☐ Participant ☐ Carer/Family/Guardian ☐ Support Coordinator

Review and Confirmation

Please review and confirm that the information provided is accurate and complete before submitting this referral. By submitting, you confirm the accuracy of the data for NDIS service planning.

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Consent & Privacy Declaration *

I confirm that the information provided is accurate to the best of my knowledge, and I consent to Amaze ConnectCare contacting me to discuss the referral.

☐ I am the participant ☐ I am submitting on behalf of the participant

By submitting this referral, I confirm that the participant (or their authorised representative) has provided informed consent for Amaze ConnectCare to collect and use their personal and health information to assess and deliver NDIS support services.

I understand that this information will be stored securely and handled in accordance with the Privacy Act 1988 (Cth) and Amaze ConnectCare's privacy policy. I also acknowledge that this information may be shared with relevant professionals only when necessary to provide appropriate support, or as required by law.

Name: _____

Signature: _____

Date: ____ / ____ / ______

Submit the completed form via Email to info@amazecc.com.au
Our team will contact the nominated person within 1 business day.