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| Before you fill in the form Under the ***National Disability Insurance Scheme (Authorisations) Act 2019*** section 14(2)(iii) an application for an authorisation or interim authorisation must include information that shows the **implementing provider has engaged in consultation about the proposed use** of a restrictive practice with:   1. The participant; and 2. The participant’s family, carers, guardian/s or other relevant person. |

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| 1. Application Details | | | |
| Date | Click or tap to enter a date. | | |
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| 1. NDIS Participant Details | | | |
| Given Name  Surname | Click or tap here to enter text.  Click or tap here to enter text. | NDIS Participant Number | Click or tap here to enter text. |
| Date of Birth | Click or tap to enter a date. | | |

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| 1. Consultation |
| Provide information that shows the provider has engaged in consultation about the proposed use of a restrictive practice with:  (a) the participant; and  (b) the participant's family, carers, guardian/s or other relevant person.  Note: This is evidence of discussions/consultations the Service Provider has had with stakeholders, separate to the consultations the Behaviour Support Practitioner may have completed with stakeholders in the course of developing a behaviour support plan. |

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| 1. Consultation details\* | |
| 1. **Please name the tools or resources you used to assist your communication with the Participant.** | Click or tap here to enter text. |
| 1. **Please describe the Participant’s reaction to the restrictive practice, either their verbal response or description of your observations.** | Click or tap here to enter text. |
| 1. **How do you plan to improve Participant consultation in the future?** | Click or tap here to enter text. |
| 1. **Was an appropriately accessible version of the behaviour support plan provided?** \*National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. | Click or tap here to enter text. |
| 1. **Please describe how you consulted with the Participant’s family, carers, guardian/s or other relevant person.** | Click or tap here to enter text. |

\*Attach any additional documents to support your evidence of consultation.

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| **Signature** |  |
| **Full Name** | Click or tap here to enter text. |
| **Job Title** |  |
| **Service Provider Name** |  |
| **Date** | Click or tap to enter a date. |
| Further information Please contact [restrictive-practices.authorisation-unit@nt.gov.au](mailto:restrictive-practices.authorisation-unit@nt.gov.au) or 08 8999 2431  Upload this signed form with your authorisation request: <https://nthealth-sngy7thh.patientsafety.com/portal/#/form/74c6d18c-eef8-4b86-88ca-44fa22282270> | |
| End of form | |
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