National Premier
Disability Services Pty Ltd.

2018
NDIS

CLIENT EXIT / TRANSITION FORM

NATIONAL PREMIER DISABILITY SERVICES

ADMIN | 0412 712 303

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Date: ___________ Assessing Staff Member: ________________

CLIENT DETAILS

Surname _____________________________ First Name __________________________

Date of Birth: _________________________ Gender: _____________________________

Age: ________

GUARDIAN DETAILS (if applicable)

Surname ____________________________ First Name __________________________

OTHER STAKEHOLDERS INVOLVED IN TRANSITION PLANNING

Surname ____________________________ First Name ___________________________

Position _____________________________ Organisation _________________________

Surname ____________________________ First Name ___________________________

Position _____________________________ Organisation _________________________

TRANSITION / EXIT PLAN

What are the client's exit or transition goals?

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What strategies / actions have or can the client and National Premier Disability Services put in place to achieve these goals?

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What referrals and linkages to other services and activities will best meet the client's needs?

Timeline and responsibilities for exit/transition:

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AGREEMENT

☐ All parties agree with this Exit/Transition Plan.

☐ A copy of this Exit/Transition Plan has been provided to the child's parent/guardian.

Parent/Guardian

I have been provided with information regarding:

☐ Other support National Premier Disability Services can offer;

☐ The potential outcomes of my decision to exit National Premier Disability Services; and

☐ How to re-enter National Premier Disability Services in the future should my needs or circumstances change.

☐ I consent to my information being provided to other organisations to support my or transition.

Client/Guardian

Full Name ______________________________ Date _________________________________

Signature of Parent/Guardian ____

Assessing Staff Member

Full Name ___________________________ Date__________________________________

Signature of Staff Member ____

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