**REFERRAL FORM**

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| --- |
| **Client Details (Complete for person requiring supports)** |
| Client Name |  | DOB |  |
| Email |  | Phone |  |
| Address |  | Postcode |  |
| Suburb |  | Communicate with | [ ]  Client [ ]  Referrer [ ]  Authorised Person |
| Is an Authorised Person / Guardian appointed? | [ ]  Yes[ ]  No | If ‘yes’, please complete below details |
| Authorised Person |  | Relationship |  |
| Email |  | Phone |  |

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| **Referrer Details (Person making this referral, if not the client)** |
| Referrer |  | Role |  |
| Email |  | Phone |  |
| Company |  |

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| **Service Details** |
| What services are required (select multiple if necessary) | [ ]  OT Assessment / Report[ ]  Capacity Building[ ]  Assistive Technology[ ]  Therapy Assistant Support | [ ]  Home Modifications[ ]  Housing Report[ ]  Community Access Plans[ ]  Prepare for School | [ ]  OT Driving Assessment[ ]  Vehicle Modifications[ ]  Mobility Assistance[ ]  Prepare to Drive |
| Diagnosis / Diagnoses(list all that are applicable) |  |
| Preferred Location for Service Delivery | [ ]  Home[ ]  School | [ ]  Community[ ]  ARTS Clinic |
| Are there any safety concerns our team should be aware of? (eg: mental health, violence, criminality, smoking / substance use, behaviours of concern)? [ ]  No [ ]  Yes (please state) |  |
| Is the client receiving any other supports? | [ ]  Yes[ ]  No | If ‘yes’, please state: |

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| **Payment for Services** |
| Payment method | [ ]  NDIS Funded (complete below) [ ]  Privately Funded [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| NDIS Number |  | NDIS Plan Dates |  |
| Plan Management | [ ]  Agency / NDIA Managed [ ]  Self-Managed [ ]  Plan Managed (complete below) |
| Plan Manager |  |
| Email for Invoices |  |

Other Details: