**REFERRAL FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 | |  |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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: