**NDIS Participant Referral**

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| **Participant Details:** | |
| First Name/s: Click or tap here to enter text. | Last Name:Click or tap here to enter text. |
| D.O.B:Click or tap to enter a date. | NDIS Reference #: Click or tap here to enter text. |
| Address:Click or tap here to enter text. | |
| Phone: Click or tap here to enter text. | Email: Click or tap here to enter text. |
| GP Name: Click or tap here to enter text. | GP Practice: Click or tap here to enter text. |
| Medication Summary and Past Medical History | Please attach to referral and/or provide a summary below;  Does the client consent to us contacting GP or other involved health professionals for this information? Yes No |
| Best Name and contact for appointments: Click or tap here to enter text. | |

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| **NDIS Participant Representative (if not the participant):** | |
| Relationship to participant: Click or tap here to enter text. | |
| First Name: Click or tap here to enter text. | Last Name:Click or tap here to enter text. |
| Phone: Click or tap here to enter text. | Email:Click or tap here to enter text. |
| Address: Click or tap here to enter text. | |

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| **Referrer Details** | |
| Date: | Click or tap to enter a date. |
| Referrer Name: | Click or tap here to enter text. |
| Organisation: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Contact Number: | Click or tap here to enter text. |

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| **NDIS** | | | | | | | | | | |
| Plan Start Date:Click or tap to enter a date. | | | | | Plan Review Date: Click or tap to enter a date. | | | | | |
| Fund Management Type: Choose an item. | | | | | | | | | | |
| Support Co-ordinator:  Please tick below if same as referrer | | | | | **Name:** Click or tap here to enter text.  **Organisation:**Click or tap here to enter text.  **Phone:**Click or tap here to enter text.  **Email:**Click or tap here to enter text. | | | | | |
| Plan Manager Details: (if applicable) | | | | | **Name:**Click or tap here to enter text.  **Phone:**Click or tap here to enter text.  **Email:**Click or tap here to enter text. | | | | | |
| Disability Service Co-ordinator (if applicable) | | | | | Name:Click or tap here to enter text.  Phone:Click or tap here to enter text.  Email:Click or tap here to enter text. | | | | | |
| Preferred location for appointments? I.e.: school, clinic, gym, home, school etc | | | | | Click or tap here to enter text. | | | | | |
| Support worker required to be present for appointments. | | | | | Choose an item.  Please list support worker scheduled days/hours: | | | | | |
| **Services referred for:** | | | | | | | | | | |
| Physiotherapy | | Occupational Therapy | Speech Therapy | | | | AHA | | | Exercise Physiology |
| **Referral Reason (please mark all that apply and provide details):** | | | | | | | | | | |
| Ongoing Therapy | Functional Assessment | | | Equipment Prescription | | Home Assessment | | SIL Assessment | SDA Assessment | |
| Living Skills Program | | | | | | | | | | |
| **Please Provide Details:** | | | | | | | | | | |
| Does the client consent to this referral? Choose an item.  Is the clients current NDIS plan attached? Choose an item.  Are there any other relevant medical.  records or handover from prior clinician Choose an item.  attached? | | | | | | | | | | |
| **Is the participant currently receiving supports from other services?** Choose an item.  (if yes please provide details):  Estimated remaining budget (available for use with Pilbara Therapy Services): $ Click or tap here to enter text. | | | | | | | | | | |
| **Plan Details: if NDIS plan not attached, please complete** | | | | | | | | | | |
| Background:  Short Term Goals:  Long Term Goals: | | | | | | | | | | |

Please email completed referral, along with the NDIS plan and any supporting medical reports to NDIS@pilbaratherapy.com