**NDIS REFERRAL FORM – Occupational Therapy**

**Participant details:**

|  |  |
| --- | --- |
| First Name:                         | Click or tap here to enter text. |
| Last Name: | Click or tap here to enter text. |
| Gender: | Click or tap here to enter text. |
| Date of Birth:  | Click or tap here to enter text. |
| Residential Address:  | Click or tap here to enter text. |
| Contact number: |  Click or tap here to enter text. |
| Email: |  Click or tap here to enter text. |
| Preferred Language |  Click or tap here to enter text. |
| NDIS Number:  | Click or tap here to enter text. |
| NDIS Plan Start Date:  | Click or tap here to enter text. |
| NDIS Plan End Date:  | Click or tap here to enter text. |

**Participant Representative details:**

|  |  |
| --- | --- |
| Primary Contact Person name | Click or tap here to enter text. |
| Primary Contact number : | Click or tap here to enter text. |
| Primary Contact Email: | Click or tap here to enter text. |
| If others please specify: | Click or tap here to enter text. |

**Accounts information:**

|  |
| --- |
| **FUNDING TYPE** (select one) Plan Managed [ ]  Self Managed [ ]  Agency NDIA [ ]  |
| Plan managed - Organisation name  | Click or tap here to enter text. |
| Name of person responsible for the account  | Click or tap here to enter text. |
| Contact number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |

**Referrer details:**

|  |  |
| --- | --- |
| Organisation name:  | Click or tap here to enter text. |
| Full name:  | Click or tap here to enter text. |
| Contact number  | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Job Title/ Role  | Click or tap here to enter text. |
| E-mail:  | Click or tap here to enter text. |

**Preferred Service Delivery Method**

[ ] In Person [ ] Telehealth

**PRIMARY DISABILITY / HEALTH BACKGROUND**

Please provide the primary physical disability or psychological disability

|  |
| --- |
| Click or tap here to enter text.Please select the service(s) required:[ ]  Assistive Technology [ ]  Functional Capacity Assessment[ ]  Home Assessment (simple/ complex home modifications)[ ]  Life Skills Training[ ]  Mental Health Support Services[ ]  Paediatrics[ ]  Sensory Assessment[ ]  Housing assessments (SIL/ SDA)  |

**SAFETY**

Below questions are sensitive in nature; however, we need to ask these questions to ensure our clinician’s safety. Your honest answers are appreciated. These answers are strictly confidential.

|  |  |  |  |
| --- | --- | --- | --- |
|   | **YES** | **NO**  | **Comments/Controls**  |
| Is car parking readily available  |  [ ]  |[ ]   Click or tap here to enter text. |
| House access (i.e. Front door, back door)  |  [ ]  |[ ]   Click or tap here to enter text. |
| Security instructions/special access?  (i.e. Codes)  |[ ] [ ]  Click or tap here to enter text. |
| Fire Alarm  |  [ ]  |[ ]  Click or tap here to enter text.  |
| Are the floor and exits accessible?  |[ ] [ ]  Click or tap here to enter text. |
| Mobile Phone Reception  |[ ] [ ]  Click or tap here to enter text. |
| Any Pets  |[ ] [ ]  Click or tap here to enter text. |
| Is there a history of drugs or alcohol misuse at the property? |[ ] [ ]  Click or tap here to enter text. |
| Are you aware of any firearms/weapons being stored at the property? |[ ] [ ]  Click or tap here to enter text. |
| History of family/domestic violence  |[ ] [ ]  Click or tap here to enter text. |
| History of challenging behaviors with the participant or others in the home  |[ ] [ ]  Click or tap here to enter text. |
| Does the participant have any triggers we need to be aware of?  |[ ] [ ]  Click or tap here to enter text. |
| Date completed:  Click or tap here to enter text. |

**TO COMPLETE THIS REFERRAL FORM**

Please return via email the completed form to: info@acecareservices.com.au so that we can allocate your referral.