**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](mailto:info@acecareservices.com.au) so that we can allocate your referral.