**Referral - Therapeutic Supports (OT)**

# Participant Information

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| Referral Date: |  |
| Participant Name (First/Last): |  |
| Address:  Suburb/Town/Postcode: |  |
| Telephone: |  |
| Preferred Method of Contact: |  |
| Email: |  |
| Gender/Pronouns: |  |
| D.O.B: |  |
| Participant NDIS Number: |  |
| NDIS Plan Dates: |  |
| NDIS Plan Attached: | Yes  If No, please attach plan goals |
| Management of Funds: | NDIA Agency  Self-Managed  Plan Manager |
| Confirmation of available funding in budget: | Yes Details: |
| Plan Manager (If applicable): | Name: Org:  Email: Ph: |
| Support Coordinator (if applicable): | Name:  Org:  Email:  Ph:9842 9699 |
| Other Contact (If applicable): | Name: Org:  Email: Ph: |
| Referrer Name, Phone, & Email: | Name:  Org:  Email:  Ph: |

# Responsible Person Information (if applicable)

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| **Responsible Person (if applicable):** |  |
| Address:  Suburb/Town/Postcode: |  |
| Telephone: |  |
| Email: |  |
| Level of Authority to Consent: | NDIS Plan Nominee  Legally Appointed Decision Maker  Parent/guardian of a child under 18 years |

Referral Details:

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| Details: |

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| Occupational Therapy | |
| Functional Capacity Assessment; Report, Recommendations | Seating Assessments  Child Adult |
| Home Assessment; Report, Recommendations | Sensory Profile  Child Adult |
| Wheelchair Assessment; Report  New Replacement | Handwriting Assessment; Therapy Support; Report |
| Aid/Equipment Assessment (Please specify)  New Replacement |  |
| Other Therapeutic Supports | |
| ☐ Social Work Assessment | ☐ Psychosocial Therapeutic Assessment |
| ☐ |  |
| Additional Information: | |
| Support providers you/the participant are currently working with: | |