**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  |
| [x] 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:  |