

Mobile physiotherapy and exercise physiology at home or in the community across South West Sydney. No travel fees.

* Required. Please don't include detailed clinical records in this form. We'll ask for reports separately if needed.

1 Referrer details

Referrer name *	Organisation	Role
Email *	Phone *	
Referrer is a: ☐ Support coordinator ☐ Plan manager ☐ Aged care provider ☐ GP / health professional		
☐ Client / family ☐ Other		

2 Client details

Client full name *	Date of birth (DD/MM/YYYY) *	
Client phone *	Client email (if applicable)	
Street address (for home visits) *	Suburb *	Postcode
Preferred language	Primary contact / representative (if not the client)	
Interpreter needed? ☐ Yes ☐ No		
Is the client under 18? ☐ Yes ☐ No		
Parent / guardian name (if under 18)	Parent / guardian phone	Relationship

3 Funding and service

Funding: * ☐ Support at Home ☐ NDIS ☐ Medicare ☐ DVA ☐ CTP ☐ Workers comp ☐ Lifetime Care ☐ Private

Service: * ☐ Physiotherapy ☐ Exercise physiology ☐ Not sure, please advise

NDIS participants

NDIS number	Plan start (DD/MM/YYYY)	Plan end (DD/MM/YYYY)
Plan managed by: ☐ NDIA (agency) ☐ Plan manager ☐ Self-managed		
Plan manager name and email (for invoices)	Support coordinator name and phone/email	

Support at Home clients

My Aged Care ID	Provider / care partner organisation	Care partner name and phone/email

CTP, workers compensation, Lifetime Care or DVA

Claim / reference / DVA number	Insurer or case manager name and phone/email

4 Reason for referral

Main concerns, goals or support requested *

Key date or deadline (e.g. plan review, discharge date)

How soon should we start?

5 Health and care team (optional)

GP name and practice

Other health professionals involved

Relevant conditions or history (brief)

6 Visits and home safety (helps us prepare for the first visit)

Preferred location: ☐ Home ☐ Community ☐ Gym ☐ Hydrotherapy pool ☐ Not sure

Preferred days and times

Communication or accessibility needs

Pets at the address? ☐ Yes ☐ No

Stairs or steps at entry? ☐ Yes ☐ No

Parking or access notes

Others usually at home during visits

Any known risks for visiting staff (e.g. behaviours, smoking, hazards)

7 Consent

- ☐ The client, or their authorised representative, has agreed to this referral.
- ☐ Reform Rehab may contact the client / representative about this referral.
- ☐ Reform Rehab may contact the referrer, GP, coordinator or plan manager about this referral.

We handle personal and health information under our Privacy Policy: reformrehab.com.au/privacy-policy

Name of person confirming consent *

Relationship to client

Date (DD/MM/YYYY) *

8 Send your referral

1. Save this completed PDF.
2. Email it to info@reformrehab.com.au, or call 0470 574 571.
3. We'll contact you within 24 hours. Need to send medical reports another way? Just call us.