REFERRAL FORM

NDIS Psychology Services

Please Note: Self- or Plan-Managed Only, No Agency-Managed Plans

Ability Psychology Services

Referral Information:

Participant Name & Date of Birth:

Phone & Email:

Participant Address:

Parent/s & Guardian/s (if applicable incl. POA)

Referral For:

☐ **Psychology Appointments**

Preferred Frequency:

- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ To Be Confirmed

Requested Location:

- ☐ Home Visits
- ☐ School Visits
- ☐ Online (Telehealth)
- ☐ In Clinic (North Lakes QLD)

☐ **Assessment & Report** (Common for NDIS Reviews)

Requested By (e.g. ASAP or Anticipated Review Date): _____

Report Type:

- ☐ Functional Assessment
- ☐ Cognitive Assessment
- ☐ Other:_____

Report Purpose:

- ☐ SIL / SDA Support
- ☐ Change of Circumstances
- ☐ Progress Report for NDIS Review

NDIS Information:

Eligibility (Specify Conditions Below):

- ☐ Psychosocial Disability
- ☐ Physical Disability
- ☐ Early Childhood Intervention
- ☐ Other: _____

Plan-Management Type:

- ☐ Self-Managed Plan
- ☐ Plan-Managed
  Plan Manager (Required): _____
- ☐ Agency-Managed (NDIA)
  Note: Agency-managed plans cannot be progressed.

Relevant Line Item:

- ☐ Capacity Building - Improved Daily Living
- ☐ Core Support - Therapeutic Supports
- ☐ Early Childhood Supports - Psychologist
- ☐ Other: _____

Diagnosed Conditions & NDIS Number: _____

Reason for Referral / Goal of Referral: _____

Other Relevant Referral Information, Contextual Information &/or Other Questions: _____

_____

Referral Questions & Terms:

	YES	NO
I am aware that I will be contacted to discuss this referral further and have provided my contact information.	☐	☐
I confirm that the Client is aware of and consenting to the referral, and may be contacted.	☐	☐
Are past reports, documentation or other relevant medical history available for review? Please attach to referral, or forward through when otherwise available.	☐	☐
Does the Client have a current treating health team (e.g. Psychologist, Psychiatrist, ACT / PHN engagement or similar?). Please provide relevant details above.	☐	☐
I am aware that referrals are reviewed by the relevant Intake Team and may not progress, as informed by determinations regarding the suitability and availability of services. Accordingly, I am aware that a referral does not constitute the commencement of support, or an agreement to enter into an episode of care, and thus retain independent duty of care of the client. I am aware that incorrect or insufficient referral information may limit it's progression in the Intake process. Finally, that if a referral cannot be progressed for whatever reason (e.g., if we are unable to contact the referring party and/or client), the referral will be automatically closed with no further action.	☐	☐

Referrer Name:

Signature & Date:

Phone Number & Email: _____

Best Days / Times To Reach You: _____