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| **9/246 Dorset Road, Boronia.  P.O. Box 803, Boronia, 3155 Phone/Fax: (03) 9761 1311** | Quality Lifestyle  SOLUTIONS  Occupational Therapy Consultancy |
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| **OT Referral Form** | |
| **Client Details** |  |
| **Surname:** | **Given Names:** |
| **Date of Birth:** | **Age:** |
| **Address:** | |
| **Phone:** | **Mobile:** |
| **Primary Contact (NOK/Carer/Guardian) Name:** | **Contact:** |
| **Language Spoken:** | **Intepreter: Yes/No** |
| **Communication: Verbal / Non-Verbal** | |
| **Behaviours of Concern:** | |
| **Medical History:** | |
| **Reason For Referral:** | |

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| **Funding Details** |  |
| **NDIS Number:** |  |
| **Plan Start Date:** | **Plan End Date:** |
| **Copy of Plan Attached: Yes / No** | **Plan Review Pending: Yes / No** |
| **Payment of Account: Self-Managed / Plan Managed / Agency Managed** | |
| **Name of Plan Management Organisation (If Applicable):** | |
| **Name of the Person Responsible For The Account:** |  |
| **Phone** | **Email:** |
|  |  |
| **OT Hours Requested** |  |
| **Is an OT Report Required: Yes / No** |  |
| **Number of OT Hours During This Funding Period:** | @ $190.00 ph (Note: Travel will be billed at the same rate) |
| **I authorise Quality Lifestyle Solutions to create a Service Booking for the hours nominated above: Yes/No** | |
|  |  |
| **Referrer's Details** |  |
| **Name:** | **Organisation:** |
| **Phone:** | **Email:** |
| **Print Name:** | **Signature: Date:** |
| **Please note that a signed service agreement needs to be in place prior to beginning services.** | |
| **Please complete and return this form by Fax: 9761 1311 or email: bronwynqls@hotmail.com** | |