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| **9/246 Dorset Road, Boronia. P.O. Box 803, Boronia, 3155Phone/Fax: (03) 9761 1311** | Quality LifestyleSOLUTIONSOccupational Therapy Consultancy |
|  |  |
| **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** |