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| --- | --- | --- | --- | --- | --- | --- |
| 1. **Referral details – Bedwetting Program** | | | | | | |
| **Service Requested** | **Bedwetting Program – Nursing Assessment & Care** | | | | | |
| **Referrer details** | Parent / family  *Please write your details in section (2)* | | | | | |
| Health Care Professional  Support Coordinator  Other  Your name: | | | | | |
| Email: | | | | | |
| Contact phone number: | | | | | |
| **Appointment preference** | Home Visit *(location dependent)*  Phone consult  Online - Zoom Teams Skype  Other:  *Please note – the Bedwetting Program can be delivered by a combination of home visit + phone/online or just phone/online* | | | | | |
| **Person to contact to set up appointment** | Parent / Family  Support Coordinator  Other | | | | | |
| 1. **Child & family details** | | | | | | |
| **Childs Name** |  | | | | | |
| **Date of Birth** |  | | | | | |
| **Address - Residential** |  | | | | | |
| **Address - Postal** | As above | | | | | |
| **Medical Diagnosis** |  | | | | | |
| **Parent(s) Name** |  | | | | | |
| **Phone number - Parent** | (Home) | | | (Mobile) | | |
| **Email Address - Parent** |  | | | | | |
| **Communication Preference** | SMS  Phone call  Email | | | | | |
| **(2) Other Contacts – Family / NOK (if required)** | | | | | | |
| Name |  | | | | | |
| Relationship | NOK  Advocate / Guardian  Other: | | | | | |
| Phone number |  | | | | | |
| Email Address |  | | | | | |
| 1. **NDIS Participants (complete if applicable)** | | | | | | |
| **NDIS Plan details for the**  **Service Agreement**  *Estimated duration:* ***10hrs*** *plus travel (if req’d), includes assessment, nursing care, reporting and recommendations.* | NDIS Reference Number | |  | | | |
| NDIA Managed – n/a (currently not available) | | Self Managed | | | Plan Managed |
| Plan Manager Company | |  | | | |
| Plan Dates | Start: | | | End: | |
| Email to send invoices to: (if known): | | | | | |
| We invoice under “Disability Related Health Supports – Nursing Supports”  Preference – use **Core Funding**  or **Capacity Building** | | | | | |
| **Person to send the Service Agreement to:** | Parent / Family  Support Coordinator  Advocate / Guardian  Other  Email (if not already included above): | | | | | |
| 1. **Non-NDIS / Other / Private fee paying client** | | | | | | |
| *Purchase of the bedwetting program can be arranged via our website shop* [www.chaptersofcare.com.au](http://www.chaptersofcare.com.au) *or via mobile card reader payments. Split payment options are available. Thank you.* | | | | | | |

Thank you for your referral – please complete & email back to [nurse@chaptersofcare.com.au](mailto:nurse@chaptersofcare.com.au)

We aim to reply within 1-2 business days to acknowledge the referral and commence the booking.