**NDIS Referral Form**

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| **Name:** | **Date:** |
| **DOB:** | **Consent given to Refer?** Yes/No |
| **Address:** | **Phone:** |
|  | **Mobile:** |
| **Contact Person (NOK/carer):** | **Phone:** |
| **Referring Organisation:** | **Email of referrer:** |
| **Name of referrer:** | **Phone:** |
| **NDIS number:** | **Plan dates:** |
| **Payment Type: PLAN managed \_\_\_\_\_\_\_\_\_\_\_ SELF Managed \_\_\_\_\_\_\_****Details (incl emails/contacts to invoice):** |
| **Name/contact details of LAC and/or Planner:** |
| **Diagnosis on NDIS plan/Medical History (attach previous reports):** |
| **Social/Home Situation:** |
| Are there safety issues? Yes/NO describe: Eg Dogs? Behaviour issues? |
| **Current Services:** |
| Name: | Hours (if applicable) | Best contact details |
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| **Current functional/emotional/cognitive/mental health problems/issues:** |
|  |
| **NDIS goals:** |
| **Urgency of Referral: Urgent: Semi- Urgent: Non-urgent:** |
| **Purpose/reason for referral: Please circle all that apply and complete blanks:** |
| NDIS Capacity building: Improved daily living: Individual assessment, therapy, training includes Assistive  technology OTHER *Total Number of hours approved:* \_\_\_\_\_\_\_\_\_ or $\_\_\_\_\_\_\_\_\_**SPlit: Occupational Therapy** \_\_\_\_\_ **Art Therapy**  \_\_\_\_\_\_ **Psychosocial counselling** \_\_\_\_ **AHA** \_\_\_\_\_\_**PEERS Social skills Group program** (Adol/Adults 2021/22) **Sensory Hub Pass** $\_\_\_\_ value (access to sensory rooms)NDIS Capacity building: Improved daily living: Allied health Assistant Level 2 \_\_\_\_\_\_\_\_\_\_\_For specific discipline related information please complete the second page |
| **Occupational Therapy Intervention: please circle all that apply** |
| Support needs assessment eg SIL) | Activities of daily living assessment | Specialist disability assessment (SDA) |
| Home modifications  | Assistive technology | Allied Health assistant support (must be supervised by OT) |
| Plan Review: date needed by: \_\_\_\_\_\_\_\_\_ | Sensory ax (maybe in support of a behavioural plan) | Interoception work (internal senses eg hunger/toileting) |
| Ongoing treatment/follow up: Details: proposed outcomes: Eg skills development in... |
| **Art Therapy Intervention: please circle all that apply** |
| Initial assessment to create ongoing plan | Ongoing therapy/treatment: Art interventions to help meet their goals | Needs added instruction / assistance during art therapy: Y / NDetail: Support available? Y N |
| CLients preferred art mediums: PENCIL, CRAYON TEXTA PAINT CLAY COLLAGE PASTELS/ CHARCOAL Movement/danceMusic/singingsculpture/pottery UNSURE? | Development of developmentally age appropriate art skills (over 8 only) | **Anticipated** Improved Daily Living Outcomes from Art Therapy:Anxiety DepressionEmotional RegulationSocial Skills CommunicationProblem Solving Personal InsightEmotional ExpressionBehaviours |
| Clients preferred Relaxation Techniques: SENSORY MEDITATION DANCE MUSIC MINDFULNESS BREATHWORK OTHER: | any extra information relevant:  |
| **Psychosocial Counselling: please circle all that apply** |
| Initial assessment to create ongoing plan | Ongoing therapy/treatment: to help meet their goals | Therapeutic Support group and/or individual sessions |
| **Relevant information:** | history of trauma | family issues/stress |
| Emotional support /Mental health support | grief/loss | adjustment to disabilityLife adjustment |
| Statutory involvement? Y N Behavioural Issues? (Positive behaviour support) Y N any extra information relevant:  |

**Thank you for taking the time to complete this form.**