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| **PERSON MAKING THE REFERRAL:**  |
| **ORGANISATION NAME**:  |
| **DATE OF REFERRAL:**  | **PHONE:**  |
| **COS/Coordinator of Care EMAIL:**  |

|  |  |
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| **CLIENT NAME:** **PREFERRED NAME:** | **DOB:** **PRONOUNS:** |
| **GENDER AT BIRTH: MALE/FEMALE/PREFER NOT TO SAY** |  |
| **FULL ADDRESS:** **Phone and email:**  |
| **Contact for appointment scheduling (if not client)?****Name:****Relationship:****Contact No:****Please indicate best place for appointment to be scheduled:*** **iThriveOT room**
* **Clients home**
* **Other community location (please nominate)**
 |
| **Diagnosis:** **G.P. and Specialist contact details:** |
| **WHO IS THE FUNDING THIS?:**  |
| **NDIS NUMBER:**  |
| **INVOICING DETAILS (who do we send the invoice to?):** |
| **Reason for Referral (FCE, ongoing OT, OTDAx, FASD Ax?)** |
| **IS THERE ANY RISK? (eg. behavioural, environmental, specific health related, please identify any triggers)** |

**PLEASE NOTE ALL THERAPY TIME IS BILLED FOR. If you attend a first session and decide not to proceed, you will be charged. If you do not attend, you will still be charged.**