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

|  |  |
| --- | --- |
| **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.**