**NDIS REFERRAL/ENQUIRY FORM** Date of Referral:

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| **REFERRER DETAILS (Person making referral)** |
| **Name:** |        |
| **Relationship to Client:** |       |
| **Name of Organisation:** |       | Email: |       |
| **Phone:** |       | Mobile: |       |
| **Are you able to provide any reports or assessments?** |  |

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| If proceeding, who will be signing the Service Agreement?  | **Name**: |
| Do you require “easy read” Agreement and documentation? | [ ]  Yes [ ]  No  |

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| **CLIENT/PARTICIPANT DETAILS** |
| **Title & Name:** |   |
| **Date of Birth:** |  |
| **Gender:** | [ ]  Male [ ]  Female [ ]  Trans/Intersex/Another identity/undisclosed |
| **Address:** |  |
| **Email:** |  | Mobile: |  |
| **Primary NDIS Diagnosis:** |  |
| **Please list any other disability, health and/or medical conditions:** |  |
| **Behaviour:** *are there any behaviours of concerns, criminal history or use of drugs - past or present?* | [ ]  Yes [ ]  No If yes, please provide details:  |
| Are You from Aboriginal or Torres Strait Islander Descent? | [ ]  Yes [ ]  No |

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| **[ ]  LEGAL GUARDIAN OR TRUSTEE** **[ ]  NDIS REPRESENTATIVE** **[ ]  PREFERRED CONTACT PERSON**  |
| **Full Name:** |  | Relationship: |  |
| **Address:** |  |
| **Email:** |  |
| **Home Phone:** |  | Mobile: |  |
| **Next of Kin / Emergency Contact** |
| **Name:****Address:****Relationship:****Phone/Email:** |  |

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| **NDIS PLAN DETAILS** |
| **Plan Number:**  |  | **Plan Attached**  | [ ]  Yes [ ]  No  |
| **Start Date:**  |  | **Plan End Date:** |  |

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| **PAYMENT DETAILS** |
| **NDIS Plan management** | [ ]  Self-Managed  | [ ]  Plan Managed  |
| **Name of Contact Person:** |  |
| **Phone Number:** |  |
| **Email:** |  |
| **Organisation (if applicable):** |  |
| **Address:** |  |
| **SERVICES REQUIRED** |
| **What OT services/ assessments are specifically required**[ ]  Functional Capacity Assessment [ ]  Ongoing Occupational Therapy[ ]  Housing Exploration Report (specify if SIL and/or SDA below)[ ]  Other (please specify):**Please provide further details below:** |

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| **FUNDING ALLOCATION FOR THE SERVICES WITH INTRACARE** |
| **Name of person confirming funding availability**  |  |
| **Amount allocated**  | $  |
| **Frequency of services required (e.g., weekly, fortnightly)** |  |