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

|  |  |  |  |
| --- | --- | --- | --- |
| **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)** |  |