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?			

If proceeding, who will be signing the Service Agreement?	**Name**:
Do you require "easy read" Agreement and documentation?	☐ Yes ☐ No

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

☐ 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:**	

NDIS PLAN DETAILS			
Plan Number:		**Plan Attached**	☐ Yes ☐ No
Start Date:		**Plan End Date:**	

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:

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