CLIENT REFERRAL FORM

NORTHERN
OCCUPATIONAL
THERAPY SERVICES

1. Client Details

Full Name (First & Last):	
Date of Birth (DD/MM/YYYY):	Residential Address:
Contact Number:	Guardian / Next of Kin / Alternative Contact Details (Name, Phone, Relation):
Coordinator of Support (name, email & phone):	House Manager (name, email and phone):

2. Referrer Details

Name of Referrer:	Contact Person to Discuss Referral (if different):
Email Address:	Phone Number:
Nature of Relationship to Client: [ ] Client (Self) [ ] Guardian / Parent [ ] Support Coordinator [ ] Case Worker [ ] Health Professional [ ] GP [ ] Other (please specify): _____	

3. Services Required

Please check all services that apply to this referral:

- **[ ]** Initial Functional / Comprehensive Assessment
- **[ ]** Capacity Building / Ongoing Therapy
- **[ ]** Home Modifications (Minor / Major)
- **[ ]** Assistive Technology Prescription (Equipment / Aids)

4. Funding Type

Please select the primary funding pathway:

Aged Care **[ ]** Support at Home **[ ]** CHSP **[ ]** Transition Care

[ ] NDIS (National Disability Insurance Scheme) NDIS # _____Plan End Date_____

[ ] Agency Managed [ ] Plan Managed [ ] Self-Managed

[ ] Medicare (Chronic Condition Management Plan - CCMP) #_____Date_____

[ ] Medicare (Mental Health Care Plan - MHCP) #_____Date_____

[ ] Third-Party Compensation Scheme (e.g., TIO, WorkSafe, DVA) claim #_____

[ ] Self-Funded / Private **[ ]** Other (please specify): _____

NDIS Only: Please include screenshot of Improve Daily Living (IDL) funding category from the participant's current NDIS plan showing the description of the funding allocation in the category i.e. any stated hours or therapy supports. This information allows intervention planning with consideration to funding periods.

5. Reason for Referral / Medical History

Please provide details regarding the client's current challenges, primary diagnosis, condition they have met access for (if NDIS) and goals:

6. Client Consent

Mandatory Consent Confirmation:

Please confirm you have obtained consent from the client to make this referral, which includes sharing the client's personal and medical details, and agreement to be contacted by Northern OT Services for the purpose of providing services to the client.

[ ] I have consent from the client to make this referral.

Referrer Signature: _____ Date: _____

Please return completed forms via email to info@northernots.com.au
Northern OT Services | Phone: 0400 297 074