



New Client / Referral Form

This form may be completed by a GP, health professional, support coordinator, or by the client themselves.

Referrer Details

Name:

Role: GP, Allied Health, Specialist, Support Coordination, Other:

Organisation / Practice (if applicable):

Phone:

Email:

Client Details

Full Name:

Date of Birth:

Pronouns (optional):

Phone:

Email:

Address / Suburb:

Best way to contact client: Phone Email Text

Is the client aware of this referral?

Funding Information

Funding Type

- NDIS
- Private
- Medicare Enhanced Primary Care Plan
- Other:

If NDIS:

NDIS Number:

Plan Management: Plan Managed, Self Managed, Agency Managed

Plan Manager (if applicable):

Plan Dates:



Services Requested

- Exercise Physiology Home Visit
- Exercise Physiology Telehealth
- Disability Support Work
- Girls Social Support Group

Primary Reason for Referral

(Please tick all that apply or add your own)

- Autism
- ADHD
- Chronic pain
- Chronic fatigue / long covid
- Dysautonomia (e.g. POTS)
- Hypermobility / HSD
- Ehlers Danlos Syndrome
- Endometriosis
- Menopause
- PCOS
- Cancer (current or remission)
- Mental Health
- Autoimmune Disease (please specify):
- Anxiety related to movement or exercise
- Low muscle tone
- Intellectual Disability
- Other:



Relevant Medical / Functional Information

(Please include diagnoses, symptoms, precautions, or anything helpful for safe support)

Goals for Support

Consent & Information Sharing

- I confirm that the client consents to this referral and to Blossom Therapy & Supports contacting them.
- I consent to relevant information being shared between Blossom Therapy & Supports and the referrer for the purpose of coordinated care.

Name:

Signature:

Date:

How to Submit This Referral

Please return this completed form via:

Email: hello@blossomtherapy.au

We will contact the client within a reasonable timeframe to discuss suitability and next steps. A meet & greet may be arranged prior to commencing services.