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**MC OCCUPATIONAL THERAPY**

**PARTICIPANT REFERRAL FORM**

**Participant name:**   **Date of birth:**

**Address for assessment:**

**Participant contact details:**

**Considerations/risks (CALD, Language, special req):**

**Nominee/guardian contact details:**

**NDIS Number: NDIS Plan Dates:**

**Referrer name:**   **Referrer organisation:**

|  |  |  |
| --- | --- | --- |
| **NDIS Managed:** | **Yes** | **No** |
| **Plan Managed:** | **Yes** | **No** |
|  | Plan manager name | Phone:  Email: |
| **Self Funded:** | **Yes** | **No** |

|  |  |
| --- | --- |
| **Allied Health Services requested. Please circle/tick** | |
| Occupational Therapy | Physiotherapy |
| Personal training | Psychologist |
| Podiatry | Speech Therapy |

**Circle/tick referral reason/s (specify if other):**

🞏 Functional Capacity Assessment 🞏 Plan review approaching for more funding

🞏 Supported Independent Living/Specialist Disability Accommodation (SIL/SDA/ILO)

🞏 Social Housing application/review report 🞏 Services Australia report/Centrelink

🞏 Psychologist counselling/CBT 🞏 Psychometric testing (IQ/behavioural)

🞏 Capacity building with allied health assistant 🞏 Other:

|  |
| --- |
| **Home modifications and areas of concern**  🞏 Access ramps 🞏 Stairs/steps 🞏 Handrails 🞏 Bathroom 🞏 Bedroom  🞏 Other: |

|  |
| --- |
| **Assistive Technology/equipment (please tick/circle required)**  🞏 hospital bed/mattress 🞏electric recliner chair 🞏 walking aids 🞏 transfer aids  🞏 power/manual wheelchair 🞏 pressure care/cushion 🞏 vehicle modifications  🞏 shower chair/mobile commode 🞏 Over-toilet aid/toilet surround  **🞏 Other:** |

*Cancellation Policy: If the Participant or Participant’s Representative fails to provide more than 24 hour notice (SMS or telephone the provider mobile number) of a cancellation of a consultation, or is not present for the consultation at the scheduled date and time, then cancellation fees will apply in congruence with NDIS rules and regulations at the time of referral being accepted and scheduled.*