



## Referral for NDIS Services

Please ensure all sections of this referral are completed in order for it to be processed in a timely manner. Email completed form to [reception@alliancerehab.com.au](mailto:reception@alliancerehab.com.au) or fax through to (07) 4771 6971.

### Personal Details

Family name: \_\_\_\_\_ Phone (Home): \_\_\_\_\_  
Given name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Sex:  Male  Female

### How would you like us to contact you?

Phone  Email  Text  Via Mail/Post: \_\_\_\_\_  
 or another person contacted on my behalf: \_\_\_\_\_

### Who is your:

**Support Coordinator:**  
Name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_  
 **Local Area Coordinator:**  
Name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_  
 **Support Worker**  
Name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_  
 **Contact Person for Appointments and Scheduling**  
Name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_

### About Me:

### Primary disability & health history:

### My NDIS Goals:

### Reason for referral:

**Services you would like to access at Alliance Rehabilitation:**

- |  |  |
|--|--|
| <input type="checkbox"/> Physiotherapy                         | <input type="checkbox"/> Occupational Therapy        |
| <input type="checkbox"/> Social Work                           | <input type="checkbox"/> Speech Pathology            |
| <input type="checkbox"/> Dietitian                             | <input type="checkbox"/> Exercise Physiology         |
| <input type="checkbox"/> Psychology                            | <input type="checkbox"/> Hydrotherapy                |
| <input type="checkbox"/> TyroMotion (Robotic & Computer aided) | <input type="checkbox"/> Groups                      |
| <input type="checkbox"/> Driving Assessment                    | <input type="checkbox"/> Home Modifications          |
| <input type="checkbox"/> Assistive Technology                  | <input type="checkbox"/> Functional Needs Assessment |
| <input type="checkbox"/> Support Coordination                  | <input type="checkbox"/> Other Services: _____       |

**NDIS Plan Details**

**Do you have an approved NDIS Plan?:**  Yes  No

NDIS Number: \_\_\_\_\_ Plan start & end dates: \_\_\_\_\_

- I can sign Service Agreements myself  I have a Plan Nominee who signs my service agreements

**What categories of funding do you have in your NDIS Plan?:**

- Improved Daily Living  Health & Well Being  Improved Relationships  Support Coordination

**How is your NDIS Plan Managed (how are services paid?):**

- National Disability Insurance Agency(NDIA)/Portal  Self-Managed

- Plan Management Organisation pays my bills:

Name of Org: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Do you have a legal guardian via the Office of Public Guardian (OPG)?**

- Yes  No

**Has there been a recent hospital admission?**

- Yes  No (If Yes, provide Date/Reason/Length of stay & Medical Clearance from your G.P. if appropriate.)

\_\_\_\_\_

**Have referrals been sent to services other than Alliance Rehabilitation? (Please list)**

\_\_\_\_\_

**Are there other services currently involved?**

\_\_\_\_\_

**Consent for referral**

Yes - this referral has been discussed with the participant and/or their guardian, and they understand and agree with the referral being made.

**Referrer Details:**

Referrer Name: \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Discipline: \_\_\_\_\_ Fax (Work): \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_