## 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 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:**

[ ]  Physiotherapy [ ]  Occupational Therapy
[ ]  Social Work [ ]  Speech Pathology
[ ]  Dietitian [ ]  Exercise Physiology
[ ]  Psychology [ ]  Hydrotherapy
[ ]  TyroMotion (Robotic & Computer aided) [ ]  Groups
[ ]  Driving Assessment [ ]  Home Modifications
[ ]  Assistive Technology [ ]  Functional Needs Assessment

[ ]  Support Coordination [ ]  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