## Referral for NDIS Services

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| 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):

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| About Me: |

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| --- |
| Primary disability & health history: |

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| --- |
| My NDIS Goals: |

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| --- |
| 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