



Plan Details

NDIS Reference number	
NDIS Plan start date	
NDIS Plan end date	
Plan Management	<p><input type="checkbox"/> Plan Managed – Plan Manager details</p> <p><i>Name:</i> <i>Address:</i> <i>Email:</i> <i>Phone:</i></p> <p><input type="checkbox"/> Self- Managed – Details for Invoice</p> <p><i>Name:</i> <i>Address:</i> <i>Email:</i> <i>Phone:</i></p> <p><input type="checkbox"/> Agency Managed - Portal booking <i>*must have written or verbal consent for us to make a Portal booking of funds</i></p>

IMPORTANT!

To ensure we are addressing NDIS goals, it is useful for us to have a copy of the NDIS plan. Are you happy to send us a copy of the Plan? Yes No (if no, please list details of the participants goals relevant to this request for supports)



REFERRAL FOR SUPPORTS /HOURS

Therapeutic Supports	Occupational Therapy Hours requested: <input type="checkbox"/> Sensory assessment <input type="checkbox"/> Functional assessment <input type="checkbox"/> Wheelchair assessment <input type="checkbox"/> Self-management	<input type="checkbox"/> Seating assessment <input type="checkbox"/> Fine motor <input type="checkbox"/> Skills Development – Daily Living <input type="checkbox"/> Equipment – AT <input type="checkbox"/> Home modifications
	Speech Pathology Hours requested <input type="checkbox"/> Meal- time assessment/review <input type="checkbox"/> Communication assessment <input type="checkbox"/> Communication support	<input type="checkbox"/> Articulation <input type="checkbox"/> Social skills <input type="checkbox"/> Equipment <input type="checkbox"/> Other
	Physiotherapy Hours requested <input type="checkbox"/> Gait analysis <input type="checkbox"/> Mobility <input type="checkbox"/> Assessment of transfers	<input type="checkbox"/> Balance & coordination <input type="checkbox"/> Strength and endurance <input type="checkbox"/> Equipment <input type="checkbox"/> Other
	Psychology /Behaviour Support/Counselling Hours requested <input type="checkbox"/> Psychology Assessments <input type="checkbox"/> Emotional coping strategies <input type="checkbox"/> Social skills	<input type="checkbox"/> Improved Relationships <input type="checkbox"/> Specialist Behaviour Support <i>(Intervention, Management and Implementation of Plans)</i>
	Dietitian Hours requested <input type="checkbox"/> Diet Assessment and Advice <input type="checkbox"/> Weight Management <input type="checkbox"/> Diet and Meal Plan Community Nursing Hours requested <input type="checkbox"/> Continence Assessment and Advice <input type="checkbox"/> Wound Management and Advice	
Support Coordination	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Plan Management	Yes <input type="checkbox"/> No <input type="checkbox"/>	

RISK - Is there any other information that may be relevant to our service (eg family situation, safety issues)

Do you have any other reports from professionals you would like to share with our therapists?
 If so, please send them through via email:
yourchoiceandcontrol@gmail.com



Participants Under 18 years of age

Where would you like the service to take place? *Note: Travel will be charged from the hours approved in this request (@ ndis support item hourly rate)	<input type="checkbox"/> Home <input type="checkbox"/> School (only if school agree) <input type="checkbox"/> Kinder/childcare (only if kinder/cc agree)
*IF under 7 years (Early Childhood Early Intervention – ECEI)	<input type="checkbox"/> Any therapist who is best fit for the participant <input type="checkbox"/> NDIS approved provider only

Participants over 18 years of age

Where would you like the service to take place? *Note: Travel will be charged from the hours approved in this request (@ ndis support item hourly rate)	<input type="checkbox"/> Home <input type="checkbox"/> Day service/SDA/SIL <input type="checkbox"/> Other
Details of SDA/SIL	Service name: Contact person:

NEXT STEPS

- 🔄 Please email completed form to: yourchoiceandcontrol@gmail.com
- 🔄 For questions, please phone on 0456 708 624
- 🔄 If we require additional information, we will contact you
- 🔄 A Participant Agreement will now be developed based on the information provided. This document, along with our Welcome Pack will be sent to you and/or the participant. The Agreement and consent forms must be signed and returned before we can commence services.

THANK FOR YOU YOUR REFERRAL WE WILL BE IN TOUCH !



SC Office Use Only

- 🔗 Referral accepted **Yes** **No**
- 🔗 Therapist assigned (best match)/ Outsource Therapist
- 🔗 For NDIA managed plans, has participant given verbal approval for us to make a portal booking: **Yes** **No**
- 🔗 Will travel costs be required: **Yes** **No**

Notes and Comments