|  |  |  |  |
| --- | --- | --- | --- |
| **Client information:** | | | |
| **Name:** |  | **DOB:** |  |
| **Address:** |  | | |
| **Email:** |  | **Phone no:** |  |
| **N.O.K:** |  | **N.O.K contact:** |  |
| **Funding** | NDIS  TAC  WorkSafe  Other………………………………… | | |
| **Funding Participant no:** |  | **Support Coordinator name and contact:** |  |
| **For NDIS participants:**  **Plan type:**  **(CB Improved Daily Living section)** | NDIA managed  Self-managed  Plan Managed  Plan Nominee ……………………….. | **NDIS Plan end date:** |  |
| **Plan Manager name and contact:** |  |
| **Therapy Funds available:** |  | **Copy of NDIS Plan attached:** | Yes  No |

|  |  |
| --- | --- |
| **Disability/condition details:** | |
| **Diagnosis:** |  |
| **Relevant medical information:** |  |
| **Service Requested:** | |
| **Occupational Therapy  One-off functional assessment (Activities of Daily Living)** | |
| **Reason for referral / other comments:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral information:** | | | |
| **Referrer name:** |  | | |
| **Referrer contact:** |  | **Date of referral:** |  |

|  |
| --- |
| **Risk Assessment: Are there any risk for our staff going to see this client?**  **Yes**  **No** |
| History of violence  Behaviours of concern  Firearms  Animals  Other…………………………. |