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| **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  |

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

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

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| **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…………………………. |