Integrity. Quality. Empathy.

Allied Health & Behaviour Support Referral Form

Referrer name*

Email address*

Contact number*

How did you hear about us?*

☐ Social media ☐ Google

☐ Existing client ☐ Employee

☐ Friend/family ☐ Other provider

☐ Other - please specify

Client name*

Client D.O.B*

Please tick the boxes that apply to you

☐ Aboriginal and Torres Strait Islander

☐ Cultural and Linguistically Diverse

Interpreter required?*

☐ Yes ☐ No

If yes, please specify language

Court orders?*

☐ Yes ☐ No

Please specify

Support person/Representative required?*

☐ Yes ☐ No

If yes, please specify

☐ Guardian

☐ OPA

Diagnosis*

☐ Intellectual Disability

☐ Global Developmental Disorder

☐ Physical Disorder

☐ Autism Spectrum Disorder

☐ Acquired Brain Injury

☐ Neurological Condition

☐ Psychiatric Conditions

☐ Other - please specify

Funding type*

☐ Medicare

☐ Private (fee for service)

☐ NDIS Self Managed

☐ NDIS Agency Managed

☐ NDIS Plan Managed - please specify who

☐ Other - please specify

NDIS Plan Number*

NDIS Dates*

Service requested

- ☐ Occupational Therapy
- ☐ Art Therapy
- ☐ Physiotherapy (general)
- ☐ Dietetics
- ☐ Social Work
- ☐ Dual Diagnostic
- ☐ Positive Behaviour Support
- ☐ Therapy Led Group
- ☐ Specialist Support Coordination
- ☐ Speech Therapy
- ☐ Psychology
- ☐ Physiotherapy (hydrotherapy)
- ☐ Music Therapy
- ☐ Key Worker
- ☐ EI Behaviour Support
- ☐ Support Coordination
- ☐ Target Skills Group

Type of assessment (please tick one or more)

Psychology

- ☐ Cognitive Assessment (approx. 20 hours)
- ☐ Functional Capacity (approx. 15-18 hours)

Occupational Therapy

- ☐ Housing (approx. 20 hours)
- ☐ SIL ☐ SDA
- ☐ Assistive Technology (approx. 10-15 hours)
- ☐ Full Functional (approx. 10-15 hours)

- ☐ Activities of daily living (approx. 4 hours)

- ☐ Instrumental activities of daily living (approx. 4 hours)

Speech Pathology

- ☐ Speech or Language (approx. 3 hours each)
- ☐ Feeding/Swallowing (approx. 3 hours each)

Reason for referral / Desired outcome of Assessment or Therapy

Location of service requested*

- ☐ In Clinic ☐ Skype ☐ Home (residential)
- ☐ Home (facility) ☐ Educational Facility
- ☐ Employment Facility
- ☐ Other - please specify

Address - if applicable

Frequency of service requested*

- ☐ Weekly ☐ Fortnightly ☐ Monthly
- ☐ Other - please specify

Availability of service requested*

- ☐ AM ☐ PM ☐ Monday ☐ Tuesday
- ☐ Wednesday ☐ Thursday ☐ Friday

Is there any other information we need to consider when working with this client?

- ☐ Mobility ☐ Communication
- ☐ Behaviour ☐ Medical
- ☐ Other - please specify

Preference for Therapist*

- ☐ Male ☐ Female

Specific Clinician Name - if applicable