NDIS REFERRAL FORM

*Coast Rehab exists to support people with disabilities to engage in valued life tasks and roles. We have an experienced multidisciplinary team and provide mobile services throughout the Central Coast.*

***Please complete all sections*** *to assist us in allocating you the best possible service.*

# PARTICIPANT

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Address:**  | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |
| **Phone:**  | Click or tap here to enter text. |
| **Date of Birth:**  | Click or tap to enter a date. |
| **Height (cm):** | Click or tap here to enter text. |
| **Weight (kg)** | Click or tap here to enter text. |

# NEXT OF KIN

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Relationship:** | Click or tap here to enter text. |
| **Phone:**  | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |
| **Is this person an NDIS Nominee?** [ ]  **Yes** [ ]  **No** Click or tap here to enter text. |
| **Is there Guardianship in place?** [ ]  **Yes** [ ]  **No** **If yes, please provide details:** Click or tap here to enter text. |

# DIAGNOSIS

|  |  |
| --- | --- |
| **Diagnosis:**  | Click or tap here to enter text. |
| **Date of onset:**  | Click or tap to enter a date. |
| **Cause (if applicable):** | Click or tap here to enter text. |
| ***Please attach relevant medical reports and information to this referral:***[ ]  Previous allied health reports attached?Click or tap here to enter text.[ ]  Medical reports attached? Click or tap here to enter text. |

# REFERRER

|  |  |
| --- | --- |
| **Name:**Click or tap here to enter text. | **Company (if applicable):**Click or tap here to enter text. |
| **Phone number:** Click or tap here to enter text. | **Relationship to participant:**Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | **Date of Referral:**Click or tap to enter a date. |

# NDIS FUNDING

|  |  |
| --- | --- |
| **Participant No:**  | Click or tap here to enter text. |
| **Plan Dates:** | Click or tap here to enter text. |
| **Local Area Coordinator:** | Click or tap here to enter text. |
| **Coordinator of Supports (if appropriate):** | Click or tap here to enter text. |
| **Is there an NDIS budget for Capacity Building *“Improved Daily Living”?*** | [ ]  Yes [ ]  No |
| **How is this budget managed?**[ ]  NDIS Managed[ ]  Plan Managed (Provide details):Name: Click or tap here to enter text. Email: Click or tap here to enter text.[ ]  Self Managed (Provide Details):Name: Click or tap here to enter text. Email: Click or tap here to enter text. |
| **Where to send the Service Agreement for signing?** | Click or tap here to enter text. |
| ***Note: Adobe Sign is used for Service Agreement signing unless otherwise requested.***  |

# SPECIALIST/ GP

|  |  |
| --- | --- |
| **Name:** Click or tap here to enter text. | **Name:** Click or tap here to enter text. |
| **Phone:** Click or tap here to enter text. | **Phone:** Click or tap here to enter text. |
| **Location:**Click or tap here to enter text. | **Location:**Click or tap here to enter text. |
| ***Please list other relevant contacts (medical, allied health team)***Click or tap here to enter text. |

# REASON FOR REFERRAL

|  |
| --- |
| **Occupational Therapy** |
| [ ]  OT Functional Assessment Click or tap here to enter text.[ ]  Home Safety Assessment Click or tap here to enter text.[ ]  Wheelchair Mobility and Seating Review Click or tap here to enter text.[ ]  Bed Assessment Click or tap here to enter text. [ ]  Manual Handling Review Click or tap here to enter text.[ ]  SDA Assessment Click or tap here to enter text.[ ]  Management of Progressive Neurological Disorders Click or tap here to enter text.[ ]  Other Click or tap here to enter text. |
| **Physiotherapy** |
| [ ]  Mobility Assessment Click or tap here to enter text.[ ]  Falls Risk Assessment Click or tap here to enter text.[ ]  24 Hour Positioning Click or tap here to enter text.[ ]  Exercise and Wellbeing Click or tap here to enter text.[ ]  Hydrotherapy Click or tap here to enter text. |
| **Speech Pathology** |
| [ ]  Communication Assessment Click or tap here to enter text.[ ]  Assistive Technology Assessment Click or tap here to enter text.[ ]  Swallowing Assessment and Intervention Click or tap here to enter text.[ ]  Other Click or tap here to enter text. |
| **Dietitian** |
| [ ]  Nutrition Assessment and Review Click or tap here to enter text.[ ]  Enteral Nutrition (PEG Feeding) Click or tap here to enter text.[ ]  Other Click or tap here to enter text. |

# ABOUT THE PARTICIPANT

|  |  |
| --- | --- |
| **Additional Relevant Information** | **Comments** |
| [ ]  Speech and Communication Difficulties? | Click or tap here to enter text. |
| [ ]  Mobility Impairment? (use of aids) | Click or tap here to enter text. |
| [ ]  Cognitive Issues?  | Click or tap here to enter text. |
| [ ]  Behaviour Support Plan? | Attached? [ ]  Yes [ ]  No |
| [ ] Housing History? *e.g. past 5 years, and description of what did and didn’t work for the client (for SIL or SDA report requests)* | Click or tap here to enter text. |
| [ ]  **Current Risks/Trauma History?** *e.g. self-harm or suicidal behavior; domestic violence; risks within home environment; substance-use; anger or aggression; others.* | Click or tap here to enter text. |

# PARTIPANT GOALS (As per NDIS Plan)

|  |  |
| --- | --- |
| **Goals:** | Click or tap here to enter text.Click or tap here to enter text.Click or tap here to enter text.Click or tap here to enter text. |

# SUMMARY OF ALLOCATION FOR THERAPY SUPPORTS (from NDIS plan)

*Only completed If required by coordinator of supports with permission from the participant in order to proceed with intervention services provided by Coast Rehab.*

|  |  |  |
| --- | --- | --- |
| **Service:** | **Allocated Hours:** | **Objectives:** |
| **Occupational Therapy** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Physiotherapy** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Speech Therapy** | Click or tap here to enter text. | Click or tap here to enter text. |
| **Dietitian**  | Click or tap here to enter text. | [ ]  Health & Well Being[ ]  CB Daily Living  |

**Please send to** **Admin@coastrehab.com.au**

**Thank you for your referral to Coast Rehab.**

**We look forward to working with you.**