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**](mailto:Admin@coastrehab.com.au)

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

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