THERAPY CIRCLES
AUSTRALIA
SURROUND YOURSELF WITH CARE

REFERRAL FORM

PARTICIPANT DETAILS

Full name

Date of birth (DD / MM / YYYY)

/ /

Gender

- ( ) Male
- ( ) Female
- (✔) Other

Participant NDIS Number

Address

Phone

Mobile

Email

	Full name	Contact Number
Alternative contact person		
Emergency contact – Person 1		
Emergency contact – Person 2		
Key Support Worker		
General Practitioner (GP)		

Current Living Arrangements (With family, alone, or sharing with others)

Family Members (With family, alone, or sharing with others)

Cultural Background

- ○ **Torres Strait Islander**
- ○ **Aboriginal**
- ○ **Aboriginal & Torres Strait Islander**
- ○ **None of the above**
- ○ **Culturally and Linguistically Diverse (CALD)** (Please specify below)

Details (if applicable) (With family, alone, or sharing with others)

SOURCE OF REFERRAL

- ○ **Self**
- ○ **Family**
- ○ **Agency**
- ○ **NDIA**
- ○ **LAC**
- ○ **Other e.g Support Coordinator** (Please specify)

Name, Contact Number + Email

NEXT OF KIN / SIGNIFICANT OTHER PERSON

Full name

Relationship

Address

Phone

Email

REFERRAL FORM

DIAGNOSIS

Please Provide Details if Applicable

Primary Diagnosis	
Secondary Diagnosis/Comorbidities	
Current Treatments	
Current Medications	
Assistance Required With Medication?	
Does The Individual Have Epilepsy, Seizures, Asthma, Allergies?	
Details Of Past Hospital Admissions	
I Grant Permission To Access My My Medical Records	◯ Yes ◯ No
Assistance Required With Mobility E.g., Wheelchair, Walker, Hoists?	
Any Other Safety Concerns, Or Behaviors Of Concern Etc?	
Any Other Assistive Devices In Use?	
Any Details Of Past Therapists?	

REFERRAL FORM

REASONS FOR THIS REFERRAL

Details if Applicable, Or Hours/Week

- ○ Physiotherapy
- ○ Speech Pathology
- ○ Occupational Therapy
- ○ Therapy Assistants

FUNDING

Who manages your NDIS funding?

○ Agency Managed ○ Plan Managed ○ Self- Managed

If Plan Managed, provide Plan Manager contact details

Full name

Phone

Email

NDIS Number

NDIS Plan Start Date

NDIS Plan End Date

HOW DID YOU HEAR ABOUT US?

REFERRAL FORM

OFFICE USE ONLY

Referral Outcome ◯ Referral Accepted ◯ Referral not Accepted

Name/Position

ACCEPTED

Details

Allocation Date

Date entered on the database

Notes

NOT ACCEPTED

Details

Reason not accepted

Comments/Actions e.g., referred on to [name of service]