THERAPY CIRCLES
AUSTRALIA
SURROUND YOURSELF WITH CARE

NDIS REFERRAL FORM

PARTICIPANT DETAILS

Full name

Gender

Male Female Other

Address

Date of birth (DD / MM / YYYY)

/ /

Phone

Email

Mobile

REPRESENTATIVE/GUARDIAN

Full name

Relationship

Email

Contact Number

EMERGENCY CONTACT

Full name

Relationship

Email

Contact Number

NEXT OF KIN

- ◯ Same as representative/guardian
- ◯ Same as emergency contact
- ◯ Enter next of kin details below

Full name

Relationship

Email

Contact Number

MEDICAL POWER OF ATTORNEY

- ◯ Same as representative/guardian
- ◯ Same as emergency contact
- ◯ Same as next of kin
- ◯ Enter medical power of attorney details below

Full name

Relationship

Email

Contact Number

LIVING ARRANGEMENTS & CULTURAL BACKGROUND

Current Living Arrangements (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) (Share details of your cultural background if you wish)

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Is an interpreter required? (For you or your representative) ◯ Yes ◯ No

DIAGNOSIS

Please Provide Details if Applicable

Primary Diagnosis

Secondary Diagnosis/Comorbidities

Current Treatments or Medications

Does The Individual Have Epilepsy, Seizures, Asthma, Allergies?

Assistance Required With Mobility E.g., Wheelchair, Walker, Hoists?

Details Of Past Hospital Admissions

Any Details Of Past Therapists?

Any Other Safety Concerns, Or Behaviours Of Concern Etc.?

SOURCE OF REFERRAL

◯ Self ◯ Family ◯ Agency ◯ NDIA ◯ LAC

◯ Other e.g. Support Coordinator (Please specify)

Referrer full name

Referrer phone

Referrer email

NDIS REFERRAL FORM

MEDICAL CONTACTS

Main Doctor/GP full name

Clinic name

Contact Number

I Grant Permission To Access My Medical Records

◯ Yes ◯ No

REASONS FOR THIS REFERRAL

Current NDIS Budget/Hours

◯ Physiotherapy

◯ Speech Pathology

◯ Occupational Therapy

◯ Therapy Assistants

If you have requested Speech Pathology, are you experiencing any of the following problems?

◯ Swallowing difficulties

◯ Trouble learning

◯ Trouble finding the right words

◯ Memory difficulties

◯ Voice difficulties

◯ Trouble starting/finishing tasks

◯ Hearing difficulties

◯ Difficulty being understood by others

◯ Trouble understanding others

◯ Other

Preference For Male/Female Practitioner

◯ Male ◯ Female ◯ No preference

NDIS REFERRAL FORM

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 DETAILS

NDIS Number

NDIS Plan Start Date

NDIS Plan End Date

CLOSEST BRANCH

- ◯ Geraldton WA
- ◯ Girrawheen WA
- ◯ Gosnells WA
- ◯ Joondalup WA
- ◯ Mandurah WA
- ◯ Midland WA
- ◯ Osborne Park WA
- ◯ Rockingham WA
- ◯ Sunshine VIC
- ◯ Werribee VIC
- ◯ Not sure

How did you hear about us?

RELEVANT DOCUMENTS

When sending your referral, please include any relevant documents including previous therapy reports, clinical care plans, screenshots of medication list.

NDIS 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]