**NDIS REFERRAL Form – Lime Therapy**

PART A – PARTICIPANT INFORMATION

|  |  |  |
| --- | --- | --- |
| **NDIS Participant Number** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NDIS Plan Dates** | **Start Date** |  | **Finish Date** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mr /Mrs / Miss / Ms / Dr** |  | **Date of Birth** |  | |
| **First / Given Name(s)** |  | **Last / Family Name** |  | |
| **Phone Number** |  | **Mobile Number** |  | |
| **Translator Required** | Yes  No Language: | | |
| **Email** |  | | |
| **Residential Address** |  | | |
| **Postal Address** |  | | |

PART B – PARENT / CARER INFORMATION Participant gives permission to contact?  Y  N

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship to Client** |  | | |
| **Mr /Mrs / Miss / Ms / Dr** |  |  |  | |
| **First / Given Name(s)** |  | **Last / Family Name** |  | |
| **Phone Number** |  | **Email** |  | |

PART C – PLANNER / COORDINATOR / OTHER Participant gives permission to contact?  Y  N

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship to Client** |  | | |
| **Mr /Mrs / Miss / Ms / Dr** |  |  |  | |
| **First / Given Name(s)** |  | **Last / Family Name** |  | |
| **Phone Number** |  | **Email** |  | |
| **Organisation / School** |  | | | |

PART D – NDIS PARTICIPANTS FUNDING DETAILS

**Participant Self-Managed Funding**

**Participant Funding Manage by NDIS (National Disability Insurance Agency)**

**Participant Nominated Registered Plan Management Provider (provide details below)**

**Support Coordinator Name:**

**Organisation:**

**Phone Number:**

**Email Address:**

**Copy of NDIS plan Provided**  Yes  No *If copy of plan not provided please provide goals on NDIS plan*

Additional information attached  Yes  No

PART E – DETAILS OF REFERRAL

**Referral Type**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Occupational Therapy |  | Speech Pathology |  | Driver Trained OT |
|  | Physiotherapy |  | Exercise Physiology |  | Hand Therapy |

**Reason for Referral / Referral Request (What would you like us to do?)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Pre-Planning Assessment |  | Early Intervention (0-6) |
|  | Initial Assessment |  | Capacity Building |
|  | Functional (ADL) Assessment |  | Emotional Regulation / Behaviour support |
|  | Cognitive Screen |  | Sensory Profile |
|  | Recreation / Work Services |  | Lime Legend Group |
|  | OT Driving Assessment / Learner Driver |  | Formal Speech & Language Assessment |
|  | Housing Assessment (SIL / SDA) |  | Dysphagia / Swallowing |
|  | Passenger or Driver Vehicle modifications |  | Communication |
|  | Home Modifications *(note modifications required if known)*  Access / Ramps  Bathroom  Kitchen  Other | | |
|  | Equipment Prescription (Assistive Technology) *(note equipment required if known)*  Manual / Powered Wheelchair  Electric Scooter  Mobility aid  Hoists  Commode  Pressure Care Equipment  Recliner Chairs  Electric Bed  Rails  Bidet  Alternative & Augmentative Communication (AAC)  Other | | |
|  | Hand Therapy |  | Mobility Assessment |
|  | Falls / Balance |  | Physiotherapy treatment *(note area / condition needing treatment)* |
|  | Strengthen / Conditioning |  |
|  | Exercise Program |  |
|  | Other | | |

**Information about your Disability / Diagnosis / Past Medical History** *(please provide as much detail as possible to assist us in triaging your referral and ensuring the therapist allocated is appropriate for the client and their needs)* Copy of Past Medical History attached  Yes  No

**Additional Comments**

Additional information attached  Yes  No

PART F – GP DETAILS OF THE PERSON REQUIRING NDIS SUPPORT

|  |  |
| --- | --- |
| **Is this information important?** | *We recognize the health and disability needs and supports of each participant in the NDIS. A GP is an important member of a person’s care team and we may need to communicate with the GP practice if a participant requires additional supports outside of the NDIS Plan* |
| **GP Name** |  |
| **Practice Name / Address** |  |

PART G – DETAILS OF THE PERSON COMPLETING THIS FORM

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Organisation** |  |
| **Phone** |  | **Fax** |  |
| **Email** |  | **Date of Referral** |  |

WHAT HAPPENS NEXT?

Please send this completed form along with the NDIS Plan to [admin@lime-therapy.com.au](mailto:admin@lime-therapy.com.au)

or FAX 03 5022 8355. For any additional information or assistance with completing the form please contact the friendly team at Lime Therapy on 03 5022 0955

Upon receipt of your referral the information provided will be used to triage the participant to one of our therapists, one of our team will then make contact to develop a service agreement and set up your initial appointment.