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limetherapy

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 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.