**Optimal Therapy Referral Form**

Please fill out the form below and return it to **consultations@optimaltherapy.com.au**

All fields marked with \* are required. Please note there are two pages.

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| Participant Name\*: |
| Participant Date of Birth\*: |
| Participant Contact Number\*: |
| Participant email\*: |
| Participant address\*: |
| NDIS number\*: |
| Plan Start Date\*:  Plan End date\*: |
| NDIS Funding for Capacity Building Budget\*:  Agency  Plan  Self Managed  If plan managed please provide details of plan manager\*: |
| Disability /Diagnosis\*: |
| Reason for referral\*:  Functional Capacity Assessment  Initial Occupational Therapy Assessment  Equipment  Therapy  Housing and Accommodation (SDA/ SIL/ ILO)  Other (please specify below) |
| NDIS Plan Goals:  Short Term:  Medium/Long term: |
| Preferred Contact (if not participant): |
| Will any support persons be with the participant at the initial appointment? |
| How do we safely access the participants property? \*  i.e. Are there any safety risks for the visit?  Are there stairs /locked gates/ pets? |
| If appropriate, is the participant agreeable to remote services during COVID 19 ?  Yes  No |