

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.

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 manager*:
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