**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\*:       |
| Is there a Plan Nominee who will sign the Service Agreement on the participant’s behalf (if not the participant)? \* If yes, then please provide the following details:Full Name\*:       Contact number\*:      Email address\*:       |
|  |
| 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[ ]  Self Managed[ ]  Plan 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:       |
| Will any support persons be with the participant at the initial appointment?       |
| Are there any safety risks for the visit that we should be aware of for the visit? \*      Are there stairs /locked gates/ pets? \*       |
| If appropriate, is the participant agreeable to remote services?[ ]  Yes[ ]  No  |