**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 |