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*:

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*:

Optimal Living
THERAPY

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