NDIS/Allied Health Referral Form

Form completed by:		Date completed:	

Referral Details			
Legal First name:		Legal Surname:	
Preferred Name:	Date of Birth:	Gender:	Pronouns:
Culture (select all apply)	◯ Aboriginal ◯ Torres Strait Islander ◯ Other (Please specify)		
Address:		Phone:	
Suburb:	Postcode:	Email:	
Guardian/Carer Details:	◯ Parent ◯ Guardian ◯ Carer ◯ Public Guardian ◯ Other:		
Name:		Preferred contact: ◯ Phone ◯ Email ◯ Both	
Phone:	Email:		
Other contacts: e.g. Support Coordinator, team leaders, guardian address			

Consent – to contact using information on this form to organise appointments, or capture more information.	
Provided by:	Date:
☐ Verbal consent ☐ Written consent (attach to this form)	☐ Consent to SMS ☐ Consent to Email

Do you need Communication assistance? E.g. Interpreter, Communication device	◯ Yes (Please describe) ◯ No
Diagnosis:	
Current Supports:	

Services Requesting	☐ Occupational Therapy ☐ Speech Pathology ☐ Psychology ☐ Counselling ☐ Dietetics ☐ Social Work *NDIS: Requires Improved Daily Living in Plan*	☐ Behaviour Support *NDIS: Requires Improved Relationships In Plan*	☐ Coordination of Supports ☐ Specialist Support Coordination *NDIS: Requires Support Coordination in Plan*

Participant Legal Name:	

Funding information:	◯ NDIS (add information below)	◯ Private Paying ◯ Medicare ◯ PHN – School / Preschool _____ *(go to "Service request" details)*
	NDIS Participant Number	
	NDIS Plan Start Date	**NDIS Plan End Date**
	◯ Agency Managed ◯ Plan Managed (see below) ◯ Self Managed (see below)	
	Plan/Self Managed Details	
	Send invoices to:	
	Email:	
	Phone:	
	Funding/Hours Available: Appropriate NDIS Category available (see services request)	

Service Request Details:	Is telehealth an option for all or part of the service? E.g. video link, phone call ☐ Yes ☐ No

NDIS Goals: *What are the relevant Goals on the NDIS Plan? (If applicable)*

Reason for this referral:

☐ Assessment (short-term support) ☐ Intervention/Therapy ☐ Unsure

Details: *(Include why want to see clinician, participant needs, strengths, Like/dislikes info about them)*

Please email form to ndis@marathonhealth.com.au