integrity
THERAPY SERVICES

NDIS REFERRAL FORM

1. NDIS PARTICIPANT DETAILS

Surname:	**Given Names:**
Date of Birth:	**Phone:**
Address:	**NDIS No:** **NDIS Plan No:** **NDIS Plan Dates:**
Email:	**Copy of Plan Attached:** ☐ Yes ☐ No
Occupational Therapy Approved in NDIS Plan: ☐ Yes ☐ No **Amount:**	
Living Arrangements: ☐ Alone ☐ Partner / Family ☐ Other:	
Do you identify as Aboriginal or Torres Strait Islander: ☐ Yes ☐ No	
Language other than English spoken at home: ☐ Yes _____ ☐ No	
Cultural / Religious Background:	
Preference of Occupational Therapist: ☐ Male ☐ Female ☐ No Preference Please note we may not be able to supply your choice on all occasions.	
Primary Contact? (NOK/Carer/Guardian/Other) **Name:** **Phone:** **Email:** **Relationship:**	
NDIS Local Area Coordinator (if known): **Name:** **Email:** **Phone:**	

2. REFERRER DETAILS

☐ Check this box if you are referring yourself.

Name:	**Organisation:**
Phone:	**Email:**
Role: ☐ Support Coordinator ☐ Family Member ☐ Other -	

3. DISABILITY DETAILS

Diagnosis:	
Does the Participant have any supports / services in place:	
GP:	**Organisation:**
Phone:	**Email:**
Address:	

4. SAFETY ISSUES

Is anyone at the Participant's property known to be aggressive or violent?	☐ **Yes** ☐ **No**
Are you aware of there being firearms at the property?	☐ **Yes** ☐ **No**
Are you aware of any occupant having an infectious disease (i.e. chicken pox/ shingles/ gastro, etc.)?	☐ **Yes** ☐ **No**
Are you aware of any risks related to pets or animals on the premises?	☐ **Yes** ☐ **No**
Are there any other factors we should be aware of visiting this Participant at home on our own? If YES, please describe:	☐ **Yes** ☐ **No**
Are there any risks to the Participant that you are aware of? If YES, please describe:	☐ **Yes** ☐ **No**

5. REASON FOR REFERRAL

☐ Home Assessment	☐ Pre-planning Assessment
☐ Functional (ADL) Assessment	☐ Housing Assessment - ☐ SIL ☐ SDA
☐ Home Modifications	☐ Occupational Therapy Services
☐ Assistive Technology / Equipment	☐ Other -
Details:	

6. PAYMENT OF ACCOUNT

Who is responsible for paying the account?

☐ NDIS portal and I authorise ITS to create a Service Booking for the hours nominated in a signed service agreement.

☐ Registered Plan Manager *(please complete details below)*

☐ Self *(please complete details below)*

Name of Plan Management Organisation *(if applicable):* _____

Name of person responsible for the account: _____

Phone: _____ Email for invoices to be forwarded: _____

7. ADDITIONAL INFORMATION

Please return completed form to enquiries@integritytherapy.com.au

Please note that the information provided above will form the contractual agreement between ITS and the NDIS participant or their authorised representative. It is ITS's policy that a signed Service Agreement is in place for all NDIS participants and our team will provide this to you to sign prior to, or at the time of the first OT visit. If a Service Agreement is subsequently received and the agreed role or cost of OT services differs to the above, our records will be updated to reflect the changes in the signed Service Agreement.

Print name or sign: **Date:**