

Referral Form NDIS

Date of referral

Client details

Contact for appointments

Name

Address

Email

Phone

Date of birth

Gender

 Male Female Non-binary/
genderfluid

Different identity (please specify):

Interpreter
required

 Yes No

Language/cultural background e.g. ATSI

Next of kin details

Contact for appointments

Name

Address

Email

Phone

GP details

Name

Clinic name

Phone

Address

NDIS details

A copy of the NDIS with goals is attached if consent obtained Yes No

Participant number

Funds allocated

NDIS plan dates

Capacity building Social participation

How are your funds managed? NDIA (agency managed) Self managed Plan managed

Plan Manager name:

Email Phone

Support coordinator details

Contact for appointments

Name

Service

Address

Email Phone

Services requested

Select all that apply

- Aquatic physiotherapy Occupational therapy Horticultural therapy (OT) Speech pathology
 Recreational therapy (including cycling) Dietetics Physiotherapy Social work
 OT driving assessment and training Psychosexual therapy (sex therapy)

Client availability (M-F):

Reason for referral

Primary disability / Impairment / Relevant health information

Is there a PBSP in place? If so, please provide relevant information

Yes No

Client stated goals

NDIS goals

Attached Yes No

Referrer details

Contact for appointments

Name

Service

Address

Email

Phone

Consent obtained for referral?

Yes No

If internal referral:

Consent obtained to review file?

Yes No

Approx. date of discharge

Other relevant contacts / Service providers for client

Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>
Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>
Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>
Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>
Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>
Name	<input type="text"/>	
Service	<input type="text"/>	
Email	<input type="text"/>	Phone <input type="text"/>

Submit form, or save and email
to lifeworks@royalrehab.com.au

Submit form