Referral Information

USE ADOBE ACROBAT TO COMPLETE FORM (RECOMMENDED)

Date ___ / ___ / ___

Physiotherapy and Occupational Therapy services for autistic adults or those with **mental health** as the primary diagnosis should be referred to a specialist provider for the best long-term input. **Call our Customer Engagement Team on (03) 7379 1916** with any queries.

Client Details

First name | Surname | Chosen name (if different)

Date of birth ___ / ___ / ___ | Gender identity (optional) | Pronouns (optional)

Email | Phone

Address

☐ Own / Private home ☐ Rental property ☐ Supported accommodation ☐ Aged care facility

Services Required
Please select

Specialist Services
Please select if required

Services Required	Specialist Services
☐ Physiotherapy*<·	☐ Feldenkrais Method » ☐ Vestibular Rehab ☐ Wheelchair Service
☐ Occupational Therapy*<·	☐ SENSe Clinic ☐ Wheelchair Service
☐ Exercise Physiology	
☐ Speech Pathology	☐ Videofluoroscopy ☐ Dysphagia Clinic
☐ Music Therapy	☐ Music for ABI
☐ Neuropsychology & Psychology	☐ Cognitive Assessment ☐ Behaviour Support
☐ Dietetics	
☐ Allied Health Assistant ^	

Location / Service Delivery

- ☐ Albury Clinic*
- ☐ Ballarat (NCA only)+
- ☐ Bulleen Clinic
- ☐ Deer Park Clinic
- ☐ Geelong Rooms/Gym<
- ☐ Hobart·
- ☐ Melton Clinic
- ☐ Thomastown Clinic
- ☐ Tullamarine Clinic
- ☐ Werribee Clinic
- ☐ Telehealth#
- ☐ Home Visit<~·
- ☐ Community Visit<~· (Please specify location below)

* Physiotherapy, Occupational Therapy, Speech Pathology and Allied Health Assistant support are the only face-to-face services available to clients in Albury, Wodonga, Wangaratta, Beechworth, Myrtleford and surrounds.

< Physiotherapy and Occupational Therapy are the only face-to-face services currently available to clients in Geelong and surrounds.

· Home and community visit Physiotherapy and Occupational Therapy are the only face-to-face services currently available to clients in Hobart and surrounds.

» The Feldenkrais Clinic currently only runs from our Tullamarine clinic.

^ An Allied Health Assistant program runs under therapist supervision so requires referral to the relevant therapy. Please also select the required therapy from the list above Allied Health Assistant.

+ Neuropsychology Cognitive Assessments (NCA) are the only service currently available from our Ballarat rooms.

Telehealth is available, as appropriate, to clients in all service locations.

~ Home and community visits are available to clients throughout Melbourne, Geelong, Hobart and Albury/Wodonga regions.

Telehealth
If we can provide an effective service via telehealth this will be offered.

Does the client have access to a computer, tablet or smartphone with reliable internet? ☐ Yes ☐ No ☐ Unsure

Client Diagnoses / Relevant Medical History

Client Goals / Reason for Referral
Please be as specific as possible for the therapies referred to. NDIS participants, please also forward plan / goals.

Referrer Details (note: if referring yourself or a family member, please also complete this section)

Name | Relationship to client

Organisation (if applicable)

Phone | Email

Funding Source (please select which funding arrangement best describes your situation)

- ☐ NDIS
- ☐ My Aged Care – Home Care Package
- ☐ Individual Support Package
- ☐ Chronic Disease Management (A *Referral Form for Allied Health Services under Medicare* is required from your GP)

- ☐ TAC
- ☐ MAIB
- ☐ icare
- ☐ WorkSafe

Date of injury

Claim number

- ☐ Private health insurer

Fund

Policy number

- ☐ Privately funded
- ☐ Other

NDIS Participant Details (if applicable)

Participant number | Plan dates: from ___/___/___ to ___/___/___

Payment Management

- ☐ NDIA managed
- ☐ Self managed
- ☐ Plan managed
- ☐ Nominee managed

Number of hours to attribute (if known)

If unsure, would you like to allocate 10 hours to each therapy to get service underway? ☐ Yes ☐ No

Plan Manager

Who will authorise payments?

- ☐ Client
- ☐ Plan Manager

Plan Manager Details (if a Plan Manager is responsible for paying invoices on the Client's behalf)

Agency / Name

Phone | Email

Document Signatory

Who will authorise documents?

- ☐ Client
- ☐ Nominee

Nominee Details (if a Nominee is to sign documents on the Client's behalf)

Name

Relationship

Address

Phone | Email

Appointment Contact

Who should we contact regarding appointments?

- ☐ Client
- ☐ Nominee

Contact for Appointments (if a Nominee is to be contacted on the Client's behalf)

Name

Relationship

Phone | Email

Client's Preferred Day / Time for Program Sessions (accurate availability will help us determine therapist availability)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday (where available)
☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM
☐ PM	☐ PM	☐ PM	☐ PM	☐ PM	☐ PM

Emergency Contact

Who should we contact in the case of an emergency?

☐ Appointment Contact

☐ Nominee

Emergency Contact Details (if a Nominee is to be contacted on the Client's behalf)

Name

Relationship

Phone

Email

GP Details

Name

Phone

Clinic

Address

Allergies / Medical Action Plans (please outline any known allergies / medical action plans as applicable)

Day Placement / School

Name of Centre / School

Phone

Email

Address

Cultural Background (please tick if applicable)

☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally and Linguistically Diverse (CALD)

Other

Are there any cultural or religious practices or requirements our team should be aware of? ☐ No ☐ Yes (please detail below)

Primary languages spoken

Interpreter required? ☐ Yes ☐ No

Therapist Preference

Is there a preference of therapist? (we do our best to accommodate preference, but depending on availability, it cannot be guaranteed)

☐ No preference ☐ Preference (please state)

Other Information (please tick)

Current mobility status ☐ Walking ☐ Walking with aid ☐ Wheelchair ☐ Hoist transfers

What are the primary modes of communication? (please select all that apply)

☐ Speech in sentences ☐ Speech in single words ☐ Vocalisations ☐ Facial expressions ☐ Body language

☐ Gestures ☐ Key word sign ☐ Communication aids (e.g. communication board, hi-tech device, iPad – please detail below)

☐ Other modes of communication (please detail below)

Are there sensory needs we should consider to provide comfortable and inclusive therapy? ☐ No ☐ Yes (please detail below)

Does the person being referred access a Positive Behaviour Support service or experience any behaviours which require consideration or management? ☐ No ☐ Yes (please detail below)

Is there a Behaviour Support Plan in place? ☐ No ☐ Yes

Does the person being referred, or anyone we might see with this person, have a history of aggression or violence?

☐ No ☐ Yes (please detail below)

Are there any active court orders pertaining to this client? ☐ No ☐ Yes (please detail below)

History of mental illness? ☐ No ☐ Yes (please detail below)

Has hospitalisation been required within the last 5 years as a result of mental illness? ☐ No ☐ Yes

Potential issues for staff visiting? ☐ None ☐ Pets ☐ Hoarding ☐ Alcohol / drug use ☐ Firearms ☐ Other
(If yes, please detail below)

Anything else we should know?

How did you learn about NeuroRehab Allied Health Network / NeuroJunior?

☐ Support coordinator ☐ Doctor ☐ Hospital ☐ Other therapy service ☐ Friend / Family ☐ Brochure / Flyer

☐ Internet ☐ Kismet ☐ Clickability ☐ Social media ☐ Community event ☐ Expo ☐ Signage ☐ Vehicle

☐ Other:

Please tick appropriate boxes and ensure all sections are accurately completed to avoid processing delays.
Save completed form to your computer and email a copy to **services@nrah.com.au**
or click 'Submit Form' if using Adobe Acrobat to complete (recommended).

SUBMIT FORM