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| **Referral Process** |
| *To refer to WHR Allied Health, please complete this form and return it to our administration via email (**admin@whralliedhealth.com)* *or by providing the required detail by phone 0431 556 720.**Once we have received the referral details, we will contact you within 48 hours.**Please ensure consent is received from the client or their representative before completing this referral.*  |
|  **Referral Information**  |
| Referrer name |  | Referrer phone  |  |
| Referrer email |  |
| **Client Information** |
| Client Name: (as per NDIS Plan) |  | Preferred Name: |  |
| Identifies as: (please add preferences) | [ ]  She/Her [ ]  He/Him [ ]  Them/They [ ]  Refer by name |
| Cultural identity: (If you would like to share) *You may have different needs but will have the same rights and can expect the high standard of service* |  |
| Client Address: |  |
| Client DOB: |  |
| Client email: |  | Client Phone: |  |
| *If client has a representative acting on their behalf, please fill out following information:* |
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| --- | --- | --- | --- |
| Representative Name: |  | Relationship to client: |  |
| Representative Phone: |  | Representative Email: |  |
| [ ]  Contact for appointments | [ ]  Contact for service agreement | [ ]  Emergency contact |

 |
| Alternative Contact Name: |  | Relationship to client: |  |
| Alternative Contact Phone: |  | Alternative Contact Email: |  |
| *Other relevant contacts for client:* |
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|  |  |  |
| --- | --- | --- |
| Name: | Email: | Phone: |
| Position/Relationship to client: |

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| Name: | Email: | Phone: |
| Position/Relationship to client: |

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| Are you transitioning from another service provider? |  |
| WHR Allied Health uses a strengths-based approach. In the therapeutic process, it is helpful for us to know what the person enjoys doing or does well. Strengths – what do you enjoy? |
| **Disability/Diagnosis information** |
| To assist us in allocating the referral to a suitably experienced therapist in our team, please provide us with some detail about the person’s disability, any existing assistive technology/equipment and why you would like to receive support from WHR Allied Health:  |
| **NDIS Plan Details *(if applicable)*** |
| NDIS# |
| *NDIS Plan start date:*  | *NDIS Plan end date:* |
| *Please let us know if you know how many hours or the allocated budget of supports you would like allocated to WHR Allied Health supports.*  | *Flexible support budget total for WHR Allied Health* | *$* |
| *Or* |
| *OT hours/budget* |  |
| *Therapy Assistant hours/budget* |  |
| *Physiotherapy hours* |  |
| *NDIS Plan Goals:* |
| Please advise how your invoices will be managed, circling your preference as reported to the NDIA:* Self-managed
* NDIA managed
* Fund Management Provider, if so, please name the FMP: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Once we have a signed Service Agreement in place, we will provide you and the FMP with a copy so that any support hours will be quarantined to WHR Allied Health and not unintentionally accessed by another service provider without consent*. In addition, where the plan is NDIA managed, we will create a Service Booking on MyPlace based on the Service Agreement details.  |
| *Is funding available in your NDIS Plan under ‘Improved Daily Living’* | **Yes** | **No***If not, you will need to be either self/plan managed to claim OT supports. Alternatively, you can self-fund WHR Allied Health supports.*  |