|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Process** | | | | | | | | | |
| *To refer to WHR Allied Health, please complete this form and return it to our administration via email (*[*admin@whralliedhealth.com)*](mailto: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.* | | | | | | | | | |
| **Referrer/Care Manager 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:* | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | Representative Name: |  | Relationship to client: |  | | Representative Phone: |  | Representative Email: |  | | Contact for appointments | | Emergency contact | | | | | | | | | | | |
| Alternative Contact Name: | |  | | | Relationship to client: | |  | | |
| Alternative Contact Phone: | |  | | | Alternative Contact Email: | |  | | |
| *Other relevant contacts for client:* | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | Name: | Email: | Phone: | | Position/Relationship to client: | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | Name: | Email: | Phone: | | Position/Relationship to client: | | | | | | | | | | | | |
| 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/the client 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: | | | | | | | | | |
| **Home Care Package information *(if applicable)*** | | | | | | | | | |
| Have you confirmed that the client has a budget in their package to potentially fund prescribed Assistive Technology/Aids/Equipment? | | | | | | | | | |
| Please advise how the clients invoices will be managed:   * Self-managed, sent to client * Sent to referring Care Manager * Fund Management Provider, if so, please name the FMP: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| *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.* | | | | | | |