| **NDIS PSYCHOLOGY & OCCUPATIONAL THERAPY** **REFERRAL** |
| --- |

| **Referral Date:**  | **Guardian/Child Representative/Nominee consent for this referral** (*If aged under 18 or has an appointed Guardian/Nominee):* ⬜ Yes ⬜ No  |
| --- | --- |

**REFERRER DETAILS**

| **Name of referrer:** |  | **Organisation:** |  |
| --- | --- | --- | --- |
| **Referrer position/ profession:** |  | **Provider number:** *(if applicable)* |  |
| **Phone:** |  | **Email:** |  |
| **Address:** |  |

**CONSUMER DETAILS**

| **Name:** |  | **Preferred Name:** |  |
| --- | --- | --- | --- |
| **D.O.B:** |  | **Gender:**  |  |
| **☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither** | **☐ Culturally & Linguistically Diverse Background** |
| **Primary Disability:** **Secondary/Additional Disability/Disabilities:** |
| **Address:** |  | **☐ Experiencing homelessness** |
| **Phone Numbers:**  |  |
| **Email:**  |  |
| **Child Representative/ Nominee Name/Guardian:***(If aged under 18 or has an appointed guardian/Nominee)* |  |
| **Contact Details:**  |  |
| **Person to contact for making Appointment:** | **Name:****Contact Number:** **Relationship:** |

**NDIS PLAN DETAILS**

| **NDIS ID Number:** |  |
| --- | --- |
| **NDIS Plan Attached** | ⬜ Yes ⬜ No | **NDIS Plan Ends**  |  |
| **Available Funding Amount for Requested Supports: $**  |
| **Please tick at least one of the following therapies:** ⬜ Psychology Therapy: ⬜ Occupational Therapy: ⬜ Occupational Therapy FCA  | **Frequency of appointments required:** ⬜ Monthly ⬜ Fortnightly |
| **Preferred Appointment Day & Time:** |  |
| **NDIS Plan Goals:**  |

**ADDITIONAL INFORMATION**

| **Reason for Referral:** (e.g. Acute presentation symptoms, Current Stressors, historical factors) |  |
| --- | --- |
| **Any Relevant Assessments** *(e.g. OT FCA, Progress Reports)* |  |
| **Risk of harm to self/others** | **Is the person currently self-harming** | ⬜*Yes* ⬜ *No**Please specify* |
| **Is the person at increased risk of suicide, eg; Thoughts, Plan or intent** | ⬜*Yes* ⬜ *No**Please specify* |
| **Other Services Consumer is accessing:** | *Example:**Are you currently accessing OT or psychology, or have you**been trying to access OT or psychology for a period of time? If yes, please**provide details of how long you have been receiving or waiting for services.* |
| **Other relevant information:** | *Falls risks**Carer fatigue/stress**Other (If yes, please provide details):**Mobility (If yes, please provide details):* | ⬜*Yes* ⬜ *No*⬜*Yes* ⬜ *No*⬜*Yes* ⬜ *No*⬜*Yes* ⬜ *No* |

**SESSION DETAILS**

| **Preferred Location** | ☐ WWH Clinic ☐ Consumers Home ☐ Other: *Please provide details:* |
| --- | --- |
| **Home Visit Risk Assessment**  | Does the consumer live alone?  | ⬜ Yes ⬜ No |
| Are there any aggressive animals? | ⬜ Yes ⬜ No |
| Is there any clutter or tripping hazards? | ⬜ Yes ⬜ No |
| Does anyone at home have a history of violence? | ⬜ Yes ⬜ No |
| Does anyone at home have any substance abuse? | ⬜ Yes ⬜ No |
| Are there firearms in the home? | ⬜ Yes ⬜ No |
| Does anyone at home have an infectious disease? | ⬜ Yes ⬜ No |
| Is there mobile phone service at the home? | ⬜ Yes ⬜ No |
| Will there be anyone else present at the home at the time of the session? *(If yes, please provide details)* | ⬜ Yes ⬜ No |
| Are there any other risks that affect the clinician safety and wellbeing by accessing the property? | ⬜ Yes ⬜ No |
| Is there a space for the clinician and consumer to meet privately? | ⬜ Yes ⬜ No |
| **If any risks are identified, further assessment will be conducted prior to the home visit.**  |
|  | **If any yes to any questions please specify:** |

**CONSUMER PREFERENCES**

| **Preferred Gender of Worker**  | ☐ Don’t Mind ☐ Male ☐ Female |
| --- | --- |
| **Preferred Contact Methods**  | \*Okay to leave voicemail/send SMS:  | ⬜ Yes ⬜ No |
| ⬜ Mobile ⬜ Home Phone  | ⬜ Email  | ⬜ via Referrer  |
| \*If we can’t reach the consumer, do they consent to a home visit?  | ⬜ Yes ⬜ No |
| \*Is it okay to leave a letter/card at home?  | ⬜ Yes ⬜ No |
| **Other Preferences:** |  |

**SUPPORT COORDINATOR DETAILS**

| **Name:** |  | **Organisation:** |  |
| --- | --- | --- | --- |
| **Phone:** |  | **Email:** |  |

**PLAN MANAGER DETAILS**

| **Name:** |  | **Organisation:** |  |
| --- | --- | --- | --- |
| **Phone:** |  | **Email:** |  |

**How did you hear about us?**

| ⬜ Social Media⬜ Website⬜ NDIS provider finder tool⬜ Word of mouth⬜ Have worked with us previously⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- |

**Please send Referral form to Wakai Waian Healing by either of the following Means:**

**Email:** ndis@wakai-waian.com.au

**Postal:** Wakai Waian Healing, PO Box 4080 Rockhampton QLD 4700.

**For more information:**

Freecall: 1800 732 850 (Choose 4 for NDIS)