Somerset Health

REFERRAL FORM

SOURCE OF THE REFERRAL

Referrer's Contact Details:	Name: Phone: Email: Company or Organisation:
If referring for someone else, what is your relationship to the client?	☐ NDIS Support Coordinator, otherwise known as Coordinator of Supports (CoS) ☐ Parent or Guardian ☐ Partner or Spouse ☐ Medical Practitioner *If medical practitioner, what is your role?*

CLIENT DETAILS

Client's Name*: **If the client goes by any other names, has other recorded names or nicknames, please specify.*	
Client's Date of Birth:	
Client's Address:	
Indigenous Status:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None
Client's Contact Details (if available):	
Primary Language Used:	
Other Language/s Used:	

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Interpreter Required:	☐ Yes ☐ No

CLIENT FUNDING

Client Funding Type:	☐ National Disability insurance Scheme (NDIS) ☐ Private
NDIS Number:	
NDIS Plan Dates:	From: To:
NDIS Plan Management:	☐ Self-Managed ☐ Plan Managed ☐ NDIA or Agency Managed
Plan Manager Details:	Organisation/Company: Plan Manager Name: Plan Manager Email: Plan Manager Phone: Plan Manager Postal Address:
Does the client have a Behaviour Support Practitioner (BSP)?	☐ Yes ☐ No
Is the client identified as high risk by the NDIS?	☐ Yes ☐ No ☐ Unknown

CLIENT GOALS

NDIS Goals (outlined in the NDIS plan):	

Other Client Goals:	

MEDICAL INFORMATION

Primary Disability:	☐ Physical Impairment ☐ Mental Health Impairment ☐ Cognitive Impairment ☐ Neurological Impairment ☐ Developmental Delay ☐ Combination of the above
Specific Diagnosis (if known):	

OCCUPATIONAL THERAPY SERVICE REQUEST

What Occupational Therapy (OT) Service/s is Required? **If home modifications, please specify is major or minor home modifications are required, if known*	☐ Functional Capacity Assessment (FCA) ☐ Paediatric (ECEI) Assessment ☐ Equipment/AT Assessment and/or Prescription ☐ Home Modifications Assessment* ☐ SIL Assessment and Report ☐ SDA Assessment and Report ☐ Cognitive Assessment or Review ☐ Program Development (personal care skills, daily living skills, cognitive rehabilitation, sensory modulation, family/support worker training)
OT funding Allocated:	

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Please note that by completing this referral you and/or the client acknowledges:

- They consent to their information being shared with Somerset Health.
- All information obtained will be kept confidential.
- Please refer to Somerset Health's Privacy Policy for further privacy information. details.
- The referrer or client can request a copy of client records at any time.

Thank you for your referral. Somerset Health will be in touch shortly. If you have any concerns or questions, please email admin@somersethealth.com.au