360 NDIS REFERRAL FORM

We require this form to be completed in its entirety prior to an initial consultation being scheduled. It is also very helpful for our practitioners to receive the client's medical history and/or medications list prior to initial consultation. This can be obtained from the participants' usual GP.

PARTICIPANT INFORMATION

NAME		**DATE OF BIRTH**	
NDIS PARTICIPANT NUMBER		**GENDER**	
RESIDENTIAL ADDRESS		**Is the participant the best contact to arrange or change appointments?**	☐ Yes ☐ No *Please specify best person of contact below*
PARTICIPANT PHONE NUMBER		**PARTICIPANT EMAIL ADDRESS**	
EMERGENCY CONTACT NAME		**EMERGENCY CONTACT PHONE NUMBER**	

PARTICIPANT REPRESENTATIVE OR PRIMARY CONTACT

NAME		**RELATIONSHIP TO PARTICIPANT**	
PHONE NUMBER		**EMAIL ADDRESS**	

NDIS REFERRAL DETAILS

Which clinic location are you referring to:	☐ Tamworth ☐ Gunnedah ☐ Quirindi
Which Allied Health provider are you referring to:	☐ Exercise Physiology ($166.99/hour)
NDIS Plan dates	From: _____ / _____ / _____ To: _____ / _____ / _____

<table>
<tr><td>NDIS Support Category</td><td>☐ Improved Daily Living
☐ Improved Health & Wellbeing</td></tr>
<tr><td>Is the participants NDIS funding:</td><td>☐ Plan Managed
- Plan Manager: _____
- Email: _____
☐ Self Managed</td></tr>
<tr><td>NDIS Funding Periods</td><td>Proposed funding amount available for Exercise Physiology services: $_____.
OR
<table><tr><td>Funding Period
(eg 02/02/25 - 02/05/25)</td><td>Funding Amount</td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Participant’s NDIS accepted impairment/s:</td><td></td></tr>
<tr><td>Participant’s impairment category: (Please select all that apply)</td><td>☐ Intellectual
☐ Cognitive
☐ Neurological
☐ Sensory
☐ Physical
☐ Psychosocial</td></tr>
<tr><td>NDIS Plan Goals (Please include all relevant <u>capacity building goals</u> included in the participant’s NDIS plan towards which we are targeting treatment)</td><td>1.</td></tr>
<tr><td>Is this participant currently engaged with other Allied Health providers: (Please include the providers name and practice. This allows our team to deliver effective</td><td>☐ Physiotherapist - _____
☐ Dietitian - _____</td></tr>
</table>

multidisciplinary care to the participants)	☐ Podiatrist - _____ ☐ Speech Pathologist - _____ ☐ Psychologist - _____ ☐ Occupational Therapist - _____ ☐ Social Worker - _____ ☐ Audiologist - _____ ☐ Orthoptist - _____
Living arrangement: *(Please outline the participant's current living arrangements eg, SIL, at home with parents)*	
Other relevant information *(For example, chronic health conditions, supported hours, preferences for session days/times)*	
Attachments *(For example any relevant reports or letters from other providers)*	
Consent for Referral:	☐ YES ☐ NO
Urgent Referral:	☐ YES ☐ NO
Who has permission to approve and sign Service Agreements:	

CANCELLATION POLICY

Our practice will send out a SMS reminder two days prior to a scheduled appointment. This will be sent to the participant's best contact as outlined above.

- Failure to provide 12-hours' notice to cancel or reschedule an appointment will incur a 50% service fee billed to the participants funding outlined above.
- Less than 1-hour's notice, or failure to attend will incur a 100% service fee billed to the participant's funding outlined above.

REFERRER DETAILS

Person completing referral request:		**Position:**	
Phone Number:		**Email Address:**	
Company/Organisation:		**Date:**	
Signature:			

Thank you for your referral.

Our team will be in contact with you within 2 business days to make arrangements.