LIVEWELL Occupational & Hand Therapy

0438 507 660 FAX: 02 6013 9295
admin@livewellot.com.au
PO BOX 982 LAVINGTON NSW 2641
www.livewellot.com.au

OCCUPATIONAL THERAPY NDIS REFERRAL FORM

Please complete relevant information and return to Live Well Occupational & Hand Therapy Services via any of the contact details listed above.

CLIENT DETAILS	**N.O.K. DETAILS**
Mr ☐ Miss ☐ Mrs ☐ Ms☐ Other ☐: Him/He ☐ Her/She ☐ They/Them ☐	Mr ☐ Miss ☐ Mrs ☐ Ms☐ Other ☐: Him/He ☐ Her/She ☐ They/Them ☐
Surname:	Surname:
Given names:	Given names:
D.O.B: / / Language:	Relationship:
Address:	Address:
Town/City:	Town/City:
State: Postcode:	State: Postcode:
Telephone: (H):	Telephone: (H):
(M):	(B):
Email:	(M):
NDIS PLAN DETAILS	
Participant Number:	Funding Hours Allocated for OT:
Plan Start Date: / /	End/Review Date: / /
☐ Self-Managed Plan	☐ Agency Managed by NDIA
☐ Plan Managed - Organisation:	
Support Coordinator:	
Phone:	Email:
REASON FOR REFERRAL:	
☐ Assistive Technology – please provide detail:	
☐ Home Modifications – please provide detail:	
☐ Daily Living Skills Program – please provide detail:	
☐ Other:	
MEDICAL HISTORY – *PLEASE NOTE LIVE WELL OT WILL NOT ACCEPT REFERRALS FOR PARTICIPANTS WITH PSYCHOSOCIAL OR ASD AS THEIR PRIMARY DIAGNOSES* – IT WOULD BE IDEAL TO ATTACH A MEDICAL SUMMARY FROM THE GP:	

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MULTIDISCIPLINARY TEAM:

Physiotherapist – No ☐ Yes ☐:

Speech Pathologist – No ☐ Yes ☐:

Dietician – No ☐ Yes ☐:

Psychologist – No ☐ Yes ☐:

Psychiatrist – No ☐ Yes ☐:

Behavioural Support Practitioner – No ☐ Yes ☐:

Community Nursing – No ☐ Yes ☐:

Support Worker – No ☐ Yes ☐:

Medical Specialist – No ☐ Yes ☐ - please specific type of specialist & details:

-

-

Other – No ☐ Yes ☐ - please specific type of specialist & details:

SOCIAL HISTORY:

☐ Participant lives alone ☐ Participant lives with:

☐ Participant does not have children

☐ Participant has children – please advise age and living arrangement:

Social network including Family & Friends:

Productive roles – Volunteering/Employment:

HOUSING BACKGROUND:

☐ Own Home - Owner Occupied ☐ Private Rental ☐ Government Housing

☐ Supported Accommodation – Provider & Key Contact:

HAS THE CLIENT PREVIOUSLY ACCESSED OT?

☐ No – continue to next section

☐ Yes – Previous Occupational Therapist & Organisation:

Intervention completed - *Please provide a copy of any reports to Live Well OT*:
☐ Functional Capacity Assessment
☐ Assistive Technology Funding application/s – for:
☐ Minor Home Modifications - for:
☐ Major Home Modifications - for:
☐ Daily Living Skills Program - for:
☐ Other – please specify:
☐ Other – please specify:

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OCCUPATIONAL THERAPY
NDIS REFERRAL FORM

Reason for ceasing OT supports:	
DOCUMENTATION REQUIRED:	
☐ NDIS Plan Goals	
☐ Care Plans – N/A ☐	
☐ Behavioural Support Plan – N/A ☐	
☐ Medical Summary from General Practitioner	
REFERRER DETAILS	
Name:	Company:
Position:	Address:
Phone:	State: Post code:
Fax:	Email:
Is the client aware and consenting to this referral?: Y ☐ N ☐	
Date of Referral: / /	