Referral Form

KIMBERLEY THERAPY SERVICES

Participant Details:			
Name:		DOB:	
Address:			
Phone:			
Email:			
☐ Male ☐ Female ☐ Non-Binary _____ ☐ Prefer not to say			
☐ Aboriginal ☐ Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander			
Does the participant identify within the LGBTQI community? ☐ Yes ☐ No ☐ Prefer not to answer			
Emergency Contact/Next of Kin:	Name:		
	Relationship:		
	Phone:		
	Email:		

NDIS Details:	
NDIS Number:	
Plan Start Date:	
Plan End Date:	
Plan Payment:	☐ NDIS (Agency Managed)* ☐ Plan Managed ☐ Self-Managed **Kimberley Therapy Services are only able to service Plan or Self-Managed participants. If the participants funding is NDIA-Managed, we will require yourself or the Support Coordinator to submit a S48 form to the NDIS for the funding payment method to be amended. Your support coordinator can also assist with this process.*

For Plan Managed or Self-Managed:	
Organisation Name:	
Organisation Invoice Email:	

Diagnosis relevant to NDIS:

Other medical history (if applicable):

Other providers involved:

Plan Nominee/Public Guardian:	
Name:	
Organisation:	
Relationship:	
Phone:	
Email:	
Support Coordinator (If applicable):	
Name:	
Organisation:	
Phone:	
Email:	

Reason & Location of Referral:

☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Pathology ☐ Allied Health Assistant

☐ Functional Capacity Assessment

☐ Support Coordination ☐ Specialist Support Coordination ☐ Psychosocial Recovery Coaching

Location Preference:

☐ Broome ☐ Bidyadanga ☐ Dampier Peninsula ☐ Derby ☐ Fitzroy Crossing ☐Kununurra

☐ Other _____

Referral Goals - *Please describe the goals you wish to achieve with this referral and provide specific directions.*

Goals from the NDIS Plan

Referral for Services:	Hours/Funding for referral:	Travel:
Occupational Therapy		☐ MMM6 ☐ MMM7
Physiotherapy		☐ MMM6 ☐ MMM7
Speech Pathology		☐ MMM6 ☐ MMM7
Allied Health Assistant		☐ MMM6 ☐ MMM7
Functional Capacity Assessment		☐ MMM6 ☐ MMM7
Support Coordination		☐ MMM6 ☐ MMM7
Specialist Support Coordination		☐ MMM6 ☐ MMM7
Psychosocial Recovery Coaching		☐ MMM6 ☐ MMM7
Other		☐ MMM6 ☐ MMM7

Risk Assessment:	
Does the participant have a previous or current psychiatric or mental health diagnosis?	☐ Yes ☐ No
Does the participant have previous or current behaviours relating to verbal/physical violence?	☐ Yes ☐ No
Does the participant experience substance misuse?	☐ Yes ☐ No
Are there any concerns for staff to visit the participant's home?	☐ Yes ☐ No
Is the participant subject to any restrictive practices?	☐ Yes ☐ No
Does the participant have a history of self-harm or suicidal behaviour?	☐ Yes ☐ No
If yes to any of the above, please attach any relevant safety plans or risk assessments.	

Service Agreement:

☐ Send to participant via email ☐ Take to initial meeting for signing

☐ Send to (provide details): _____

Referral Completed By:			
Name:			
Relationship:		Phone number:	

Please send completed referral form to referrals@kimberleytherapy.com.au.

Clear Form