NDIS Allied Health Referral Form

Plena Healthcare

Click here for the **Group Based Training Referral Form** Click here for the **In-Home Allied Health Referral Form**

136 033 ndisbookings@plenahealthcare.com.au **Date of referral:** _____

Participant Details *Required to process referral

Name: _____ **Date of Birth:** _____

Phone Number: _____ **Gender:**

☐ Female ☐ Male ☐ Transgender/ Non Binary/ Gender Diverse

Email Address: _____ ☐ Prefer not to answer

Consumer Address: ☐ Home ☐ Facility **Preferred Booking Contact:**

☐ Phone ☐ Email ☐ Contact via NOK ☐ Contact via Case Manager

_____

Next Of Kin Contact Details / Alternative Contact Person *Required to process referral

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternative Number:** _____

Email Address: _____

Referring Person / Company Details *Required to process referral

Name: _____ **Email Address:** _____

Company: _____ **Postal Address:** _____

Phone Number: _____ _____

Payment Type + Invoicing *Required to process referral

☐ NDIS Provider ☐ Service Provider ☐ Other (please specify): _____

Provider Name: _____ **Invoice Contact Name:** _____

Coordinator's Name: _____ **Email Address for Invoices:** _____

Preferred Appointment Type *Required to process referral

Location: ☐ Face to face ☐ Telehealth ☐ No preference **Preferred Language:** _____

Therapist Gender: ☐ Female ☐ Male ☐ No preference **Is an interpreter required?** ☐ Yes ☐ No

Regular Unavailability (please provide days and times) Appointments, Care Workers, Etc.

NDIS Participants Information *Required to process referral

☐ Agency Managed ☐ Plan Managed ☐ Self-Managed

Participant ID:

Plan Start Date:

Plan End Date:

Plan Manager Name:

Plan Manager Contact Details:

Funding Area:

Support Carer / Worker Name: (If applicable)

Support Carer / Worker Contact Details: (If applicable)

Support Carer / Worker Working Hours: (If applicable)

Goals:

Occupational Therapy

- ☐ Functional Capacity Assessment (FCA)
- ☐ Manual Handling Review

Podiatry

- ☐ General Foot Care
- ☐ Corns
- ☐ Ingrown nails
- ☐ Callus or Pressure Area

Speech Pathology

- ☐ Swallowing Assessment
- ☐ Mealtime Menu Review
- ☐ Dysphagia Support
- ☐ Voice Therapy
- ☐ Communications Supports

Dietetics

- ☐ Dietary Assessment
- ☐ Meal Planning
- ☐ Nutritional Support (Oral Supplements / PEG Feeding)
- ☐ Weight Management

Other Relevant Information

All referrals to be sent directly to **ndisbookings@plenahealthcare.com.au** for triage and processing.