Allied Health Referral Form

Phone: 02 40136079
Email referral: reception@wecarensw.com.au
Mail referral: 40 Elgin St, Maitland NSW 2320

__ /__ / 20 __

Referred Client

Name: _____ Surname: _____

Date of Birth: __ /__ / ____ Age: _____ Gender: _____

Email Address: _____ Phone Number: _____

Client's Address and Other Details

Address: _____ Suburb: _____ Postcode: _____

Medicare No. ☐☐☐☐ ☐☐☐☐☐ ☐ Position on card ☐ Expiry _____

Does the client identify as: Aboriginal ☐ Torres Strait Islander ☐ Nation: _____

Other cultural and linguistic diversity ☐ _____

Aboriginal Consultant Required: Male ☐ Female ☐ N/A ☐

Referrer details

Name: _____ Organisation: _____

Position: _____ Address: _____

Email: _____ Contact Number: _____

Has the referral been discussed with the client? Yes ☐ No ☐ N/A ☐

Can the customer be contacted directly regarding this referral? Yes ☐ No ☐

Key Decision Maker

Name: _____ Contact Number: _____

Address: _____ Email: _____

Relationship to the customer: _____

Interpreter required: Yes ☐ No ☐ If yes, what language? _____

REASONS FOR REFERRAL Please feel free to contact us should you wish to clarify matters around referral.

Please outline the client's diagnoses and provide information about the main issues or concerns for the client?

_____

_____

_____

_____

_____

What outcomes are you hoping We care NSW will achieve for this client?

_____

_____

_____

_____

_____

Other Allied Health Professionals involved:

_____

_____

_____

Please indicate the type of funding available for this service to be provided?

☐ Fee for Service ☐ NDIA (if yes, please complete the details below)

☐ FACS ☐ Medicare e.g. Mental health care plan

NDIA Plan Details

Plan Number: _____ Plan Date: _____

Plan Attached: ☐ Yes ☐ No ☐ Not being attached but key goal is: _____

NDIS Plan Management and claiming details

☐ We Care NSW via Portal ☐ Plan Managed ☐ Self Managed

NDIA plan amount to be delivered by We Care NSW Allied Health Services

Improved Relationships

Amount $: _____

(Behaviour Support Plan, Interim Incident Prevention and Response Plan, Restricted Practices,

Training in behaviour management strategies)

☐ Behaviour Support

Does the individual currently have Restricted Practices in place

☐ Yes ☐ No

Comments: _____

Improved Daily Living

Amount $: _____

☐ Psychology ☐ Speech Pathology ☐ Occupational Therapy

Comments: _____

Phone: 02 4013 6079 **Fax:** 02 4058 1079
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Website: wecarensw.com.au

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Office 2: 40 Elgin St, Maitland 2320
Office 3: 2/114 Maitland Rd, Mayfield 2304