CAIRNS OCCUPATIONAL THERAPY

REFERRAL FORM – NDIS Funding **Email referral to referrals@cairnsot.com**

Participant's name: **DOB:** **NDIS No:** **Address:**	**Services will be funded by:** ☐ Does not have NDIS plan yet but has funding from: _____ ☐ Participant is Self-managing their NDIS Plan ☐ Participant is NDIA Agency Managed ☐ Participant is Plan-managed by: _____ **Email for Invoice:** _____
Participant / Carer's name and phone/mobile:	**Participant / Carer email:**

Diagnosis and Background Information (or detail separately)
Our scope of practice relates mainly to "Adult / late teen participants with primarily physical disabilities who need OT."

What OT service are you needing? Please tick relevant box and then provide more detail.
☐ Has NDIS Plan and needs **Treatment / Therapy** e.g. Hand & Upper Limb therapy, Splinting, Pain Management, Wound / Oedema Management
☐ Has NDIS Plan with approval for **home mods or equipment / assistive technology / adaptive equipment** – needs assessment and prescription by OT
Further Information:

See over

P: 07 4042 6333
F: 07 4042 6390
referrals@cairnsot.com

Suite 6, Calanna Health Centre
61 Sondrio St, Woree QLD 4868
www.cairnsot.com

Please note any risks we need to be aware of if our OT is assessing the participant at their home e.g. behavioural issues, aggressive pets?

Who is able to give consent for this service?
Participant / Guardian / Nominee / Office of the Public Guardian
Please advise name and contact details if not the participant.

Dates of the NDIS plan –

Is there any urgency around this referral? If yes, please provide details and timeframes.

Other info:

Referrers name: **Date:**

Referrer's Organisation / Relationship to participant:

Email: **Phone:**