**Referral Form**

|  |  |
| --- | --- |
| **Referral Date:** | |
| **Client information** | |
| **First name:** | **Surname:** |
| **Date of birth:** | **Gender:** |
| **Interpreter required**  **Yes**  **No** | **If yes, what language:** |
| **Address:** | **Phone number:** |
| **Email:** | **NDIS number:** |
| **NDIS Plan start date:** | **NDIS plan end date:** |
| **Primary condition(s):**  **Secondary/other condition(s):** | |

|  |  |
| --- | --- |
| **Client representative or guardian information (complete if applicable)** | |
| **First name:** | **Surname:** |
| **Relationship to the person:** |  |
| **Address:** |  |
| **Phone number:** | **Email:** |

|  |
| --- |
| **Referral information** |
| Functional Capacity Assessment  Ongoing Occupational Therapy Services  Psychosocial Recovery Coach.  Support Coordination (Level 2)  Specialist Support Coordination (Level 3) |
| **Reason for referral:** |

|  |  |
| --- | --- |
| **Funding Allocation** | |
| **What amount will be allocated for the service(s) required? (total hours or dollar value)** |  |

|  |  |
| --- | --- |
| **Support Coordinator details (complete if applicable)** | |
| **Organisation:** | **Name:** |
| **Email:** | **Phone number:** |

|  |  |
| --- | --- |
| **Plan Manager details (complete if applicable)** | |
| **Organisation:** | **Name:** |
| **Email:** | **Phone number:** |

|  |  |
| --- | --- |
| **Correspondence** | |
| **Who should Auxilium send a Service Agreement to?** | |
| To you (client) | To your guardian or representative as listed above |
| To Support Coordinator: | To another person not listed: |
| **First name:** | **Surname:** |
| **Relationship to you:** |  |
| **Address:** | **Email:** |
| **Who is the best person for all Auxilium correspondence? EG: Scheduling appointments, organising supports, important Auxilium news/announcements?** | |
| To you (client) | To your guardian or representative as listed above |
| To Support Coordinator: | Other: |

|  |  |
| --- | --- |
| **Person completing this form (i.e. the referrer)** | |
| **First name:** | **Surname:** |
| **Relationship to the person:** |  |
| **Contact details (if not listed above):** | |
| **Date form has been submitted:** | |

Please return this form to [hello@auxicare.com.au](mailto:hello@auxicare.com.au)

If you’d like to speak with us before then please call 0472 508 865.