**ABLE TO EXCEL REFERRAL FORM**

# Referrer details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full name |  | Date of referral |  | |
| Contact number/s |  | Email |  | |
| Relationship to client |  | Client gives permission to contact | | Yes  No |
| Organisation (if applicable) |  | | | |

# Referral details *(what is the request for)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Functional Capacity / Care Needs Assessment |  | Assistive technology Assessment |  | Occupational therapy treatment |  |
| Vehicle Modification Assessment |  | Driver Trained Occupational Therapy Assessment  ***(please complete the final section of this form)*** |  | Specialised motor driving instruction  ***(please complete the final section of this form)*** |  |

# Client information *(please complete in full)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title |  | | Date of birth |  | |
| Preferred pronouns | She/her/hers  He/him/his  They/them/theirs | | | | |
| First name |  | | Last name |  | |
| Are you/is the person of Aboriginal or Torres Strait Islander origin? | | | Yes  No | | |
| Contact number/s |  | | Email |  | |
| Address |  | | | | |
| Suburb |  | | Postcode |  | |
| Diagnosis / Injury |  | | Date of onset or injury (if known) | |  |
| Difficulties (please tick all known) | | Physical  Cognitive  Sensory  Behavioural | | | |
| Any safety concerns related to the client’s behaviour or visiting the client’s home | |  | | | |
| Other comments related to reason for referral | |  | | | |
| Employment status | Employed  Unemployed  Still in School  Retired  Other: | | | | |
| Capacity | I sign my own paperwork  I have a plan nominee/legal guardian (please provide details in Next of Kin section below) | | | | |

# NDIS details *(please complete in full)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Participant number |  | | | | |
| Plan dates: Start |  | | Finish |  | |
| Funding details | Self Managed  Plan Managed  **Please check that your improved daily living funding is either plan- or self managed.** | | | | ***Please note that we are not able to assist NDIA managed clients.*** |
| Plan manager details  *(if plan managed)* | Plan Manager name |  | | | |
| Contact name (if any) |  | | | |
| Contact number |  | | | |
| Email |  | | | |
| NDIS goals | 1.  2.  3.  4.  5.  6.  7.  OR  Attached to referral email. | | | | |

# Next of kin details *(if applicable)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| As per referrer details | | | | |
| Full name |  | Client gives permission to contact | | Yes  No |
| Relationship to client |  | | | |
| Contact number/s |  | Email |  | |

# Support coordinator details *(if applicable)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| As per referrer details | | | | |
| Full name |  | Client gives permission to contact | | Yes  No |
| Contact number/s |  | Email |  | |
| Organisation |  | | | |

# Driver Assessment referrals *(please complete in full if referring for a driving assessment)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Driver’s licence details | I do not have a licence | | My licence was medically suspended | | I have a learner’s permit |
| Number |  | | Expiry date |  | |
| Class |  | | Conditions |  | |
| Car transmission | Manual  Automatic | | | | |
| Car modifications or hand controls required? | | Yes  No | | | |

# PLEASE EMAIL THIS FORM TO:

# referrals@abletoexcelot.com.au