REFERRAL FORM – Occupational Therapy

Date of Referral _____

Customer Details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other _____ Date of Birth: _____

First Name(s): _____ Surname: _____

Residential Address: _____

Postal Address: _____ As above:

Email: _____

Home Phone: _____ Mobile: _____

Referrer Details

If not applicable, please go to the next section

Full name: _____ Relationship to Customer: _____

Organisation *(leave blank if not applicable)*: _____

Address: _____

Email: _____

Phone: _____ Mobile: _____

Carer, Representative, Advocate or Family Details

If not applicable, please go to the next section

Full name: _____ Relationship to Customer: _____

Address: _____

Email: _____

Phone: _____ Mobile: _____

Reason for referral (please include as much detail as possible)

_____

_____

Customer's Diagnosis / Health Condition *Please provide relevant details*

_____

Equipment Currently Used *Please provide relevant details*

_____

_____

Billing / Funding Details

☐ Self Funded ☐ NDIS ☐ WA NDIS ☐ EFL Grant ☐ Home Care Package

☐ Other _____

Person or Organisation Responsible for Invoice *(if different from Customer)*

Name / Organisation: _____

Billing Address: _____

Email: _____ Phone: _____

NDIS Number: _____ NDIS Plan Dates: _____

Send to info@thewellnessplace.com.au or to Beth@thewellnessplace.com.au