# CAIRNS OCCUPATIONAL THERAPY

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

| | |
|---|---|
| **Participant's name**:<br><br>**DOB:**<br><br>**NDIS No:**<br><br>**Address:** | **Services will be funded by:**<br>☐ Does not have NDIS plan yet but has funding from:<br>_____<br>☐ Participant is NDIA Agency Managed – we cannot help<br>☐ Participant is Self-managing their NDIS Plan<br>☐ Participant is Plan-managed by:<br><br>_____<br><br>**Email for Invoice:**<br>_____ |
| **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, Cognitive rehab
☐ Has NDIS Plan with approval for **home mods or equipment / assistive technology / adaptive equipment** – needs assessment and prescription by OT
We DO NOT offer FCAs.
We do not see children other than for above therapies.

**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:**