**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 |[ ]  Driver Trained Occupational Therapy Assessment ***(please complete the final section of this form)*** |[ ]  Occupational therapy treatment |[ ]

# 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 |  |
| 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 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