Pacific Health & WELLBEING

REQUEST FOR SERVICE

SERVICE REQUESTED

☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Pathology

REFERRER INFORMATION

Referrer Name **Organisation**

Phone Number **Email**

Relationship to Participant

CLIENT INFORMATION

Client Name **Preferred Name**

Date of Birth **Address**

Email **Contact Number**

Cultural Identity **Primary Language**

Does the Participant currently reside in ☐ SIL ☐ Foster Care ☐ Parental/Family Home ☐ Other

Known Risks for Home Visit

Primary Diagnosis

Representative/Guardian ☐ Own Decision Maker ☐ Child Protection ☐ Office of Public Guardian (OPG) ☐ Other

If other, please specify name and contact details

APPOINTMENT CONTACT (IF NOT THE SAME AS PREVIOUS)

Name of Contact **Contact Number**

Relationship to Participant

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NDIS INFORMATION

NDIS Number _____ **NDIS Plan Dates** _____

Support Coordinator (if not referrer) _____

Email _____ **Contact Number** _____

Plan Management ☐ Agency Managed ☐ Plan Managed ☐ Self-Managed

NDIS Plan Nominee _____ **Plan Manager Name** _____

Email (for invoices) _____ **Contact Number** _____

OVERVIEW OF REQUEST

Does the clinician need to liaise with any stakeholders prior to the initial assessment? (e.g. SC/Family/Nominee)** ☐ Yes ☐ No

Name and contact details of stakeholder to be contacted _____

** This may be beneficial for participants with complex care and social needs.

REQUEST

Request type ☐ Report ☐ Ongoing ☐ Both

Type of Report (if known) ☐ FCA ☐ SIL ☐ Summary Report ☐ AT ☐ Other

If ongoing, what is the desired frequency? ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other

Description of Request

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PARTICIPANTS GOALS

This information supports therapy planning and continuity of services. Without this information, access to ongoing therapy may be impacted.

Are there any reports available that could assist in the assessment process? Please attach these reports when emailing

☐ Historical Allied Health Reports ☐ Behaviour Support Plan ☐ Incident Reports ☐ Other

AVAILABILITY

Please mark **UNAVAILABILITY** only

	Monday	Tuesday	Wednesday	Thursday	Friday
AM (8am - 12pm)	☐	☐	☐	☐	☐
PM (12pm - 4pm)	☐	☐	☐	☐	☐

Thank you for completing our referral form. Please return the form to **admin@pacifichw.com.au**. If you have any questions or concerns, feel free to call our friendly Client Liaison team at (07) 3267 3287.

- If any information does not fit within the form's boxes, please include it in your referral email.
- Please note that incomplete or missing information may delay your participant's addition to our waitlist.