**Referral for Healthy Habits Program**

*PLEASE NOTE - TWO THINGS CONSTITUTE A COMPLETE REFERRAL:*

1. *ALL SECTIONS OF THIS DOCUMENT ACCURATELY COMPLETED*
2. *AN ATTACHMENT OF THE CURRENT NDIS PLAN*

*– Thank you*

|  |  |
| --- | --- |
| **Today’s date (date referred):** |  |
| **Service to be delivered by:** | My Care Provider – Healthy Habits Program |
| **Participant name:** |  |
| **NDIS number:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Participant contact phone:** |  |
| **Or contact person (relation?) inc. contact details:** |  |
| **Plan start date:** |  | **Plan end date:** |  |
| **Billing details:** | [ ]  NDIS [ ]  Plan management [ ]  Self-managed |
| **Plan manager details (for billing purposes)****Agency name:****Contact details:****Inc. invoicing email:** | (We require a name and email address)  |

|  |  |
| --- | --- |
| **What is the person really needing some practical support towards? What life skills are needed?** | Just one or two words or lines would be great.  |
| **Cultural considerations:** | [ ]  NO [ ]  YES, comment:  |
| **Interpreter required?** | [ ]  NO [ ]  YES, language:  |

|  |  |
| --- | --- |
| The allocated budget for this 2x 3hr per week, 8 week program is $3,100; 48 hours in total, billed under CB – Improved Daily Living | $ **3,100***NDIA Support Item ref. no. 15\_053\_0128\_1\_3**Or the total sum in CB – Improved Daily Living* |
| Any budget related that deserves mentioning?i.e. current supports/services in place? |  |

**NDIS Coordinator details (if applicable)**

|  |  |
| --- | --- |
| **Name:** |  |
| **Contact number:** |  |
| **Email address:** |  |

**Background Information**

|  |
| --- |
| **Primary Diagnosis**:**Secondary Diagnosis (Or suspected secondary)**: **Brief snapshot into participants life/needs**: **Anything else that you think deserves mentioning**: **Living Arrangements, relationships and supports**: **Major Risks/Concerns (to participant or us in visiting)**:  |

**Current Plan Goals (please attach the CURRENT PLAN)**

|  |  |
| --- | --- |
| **Goal:** |  |
| **Goal:** |  |
| **Goal:** |   |
| **Goal:** |  |

Please **attach any relevant assessment reports** that have been completed to date, as these will offer valuable insights.

Thank you for taking the time to complete this form in full.



**Mike Harris**

Director / Snr. Occupational Therapist

My Care Provider

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Please don’t forget to also attach the plan…