**My Care Provider - Referral Template**

*PLEASE NOTE - TWO THINGS CONSTITUTE A REFERRAL:*

1. *ALL SECTIONS OF THIS DOCUMENT POPULATED (If a section is not relevant please state: “N/A”)*
2. *A CURRENT NDIS PLAN ATTACHED (If a plan exists)*

*All referral information can be emailed to* *info@mycareprovider.com.au*

*Please note: we specialise (exclusively) in mental health (psychosocial) and cognitive disabilities; meaning that we cannot accept referrals of ‘physical disabilities/presentations’ - Thank you*

|  |  |
| --- | --- |
| **Today’s date (date referred):** |  |
| **Service to be delivered by:** | My Care Provider |
| **Participant’s name:** |  |
| **NDIS number (if relevant):** |  |
| **Date of birth:** |  |
| **Address (home visits):** |  |
| **Participant’s contact phone:** |  |
| **Or contact person (name, relation?), contact details:** |  |
| **Email addresses for report:** |  |
| **Plan start date (if relevant):** |  | **Plan end date:** |  |
| **Billing details (if relevant):** | [ ]  NDIS [ ]  Plan management [ ]  Self-managed |
| **Plan manager details (for billing purposes)****Agency name:****Contact details:****MUST INC. INVOICE EMAIL:** | (Plan or self-managed require a name and email address here)  |

|  |  |
| --- | --- |
| **What is the outcome that you are seeking (please clearly state what you are wanting from the referral):****i.e. Functional Capacity Assessment (FCAx), Intervention to build capacity in particular area of function? or both?**  | Please be clear about what you (as the participant or on behalf of the participant) are hoping to get out of the referral: We have Mike (psychosocial OT) and Therapy Assistants (Level 2) |
| **Cultural considerations:** | [ ]  NO [ ]  YES, comment:  |
| **Interpreter required?** | [ ]  NO [ ]  YES, language:  |

|  |  |
| --- | --- |
| The allocated budget for purpose of referral: (i.e. Portion of Improved Daily Living budget; Functional Capacity Ax typically require 8.5hrs @ 193.99 = $1,649) (as per Aug 2019 NDIS rates): | $ **(do not leave blank)***NDIA Support Item ref. no. 15\_056\_0128\_1\_3**Or the total sum in CB – Improved Daily Living* |
| Other areas of NDIS budget allocated:i.e. Core supports needed or in place? Capacity Building services needed or in place? | (if none or unknown, please say so)Other therapists/services in place? (Current or intended/pending) |

**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**: **Living Arrangements, relationships and supports**: **Major Risks/Concerns (to participant or us in visiting)**: **Anything else that you think deserves mentioning**:  |

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

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

Please **email any relevant assessment reports** that you believe will boost this assessment/intervention, as these can offer valuable insights.

I/we look forward to working collaboratively with you and/or your participant.

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



**Mike Harris**

Director / Snr. Occupational Therapist

My Care Provider

info@mycareprovider.com.au

1300 998 774

Please return this form, any relevant assessment and a copy of the NDIS plan (if it exists) to info@mycareprovider.com.au