NDIS
REFERRAL FORM

Holistic Speech Pathology
PO Box 282, Pomona, QLD, 4568 |
0412358372 | marni@holisticspeechpathology.com.au | www.holisticspeechpathology.com.au

NDIS PARTICIPANT DETAILS

Name

Date of Birth

Gender

Address

Suburb

State

Post Code

Email

Phone

NDIS Plan No.

Living arrangement

- ◯ Alone
- ◯ Family/Partner
- ◯ Supported Accommodation
- ◯ Other

NDIS Plan start date

NDIS Plan end date

Who is the primary contact? (NOK/Carer/Gardian)

Name

Relationship

Phone

Preferred Language

Email

Translator/interpreter or communication aids required?

REFERRER DETAILS

Please select this box if you are referring yourself or your child ◯

Name of organisation

First Name

Last Name

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REFERRER DETAILS

Phone

Post Code

Email

State

Job Title/Role: ◯ Family/Partner ◯ Health Professional ◯ Support Coordinator ◯ Other

REFERRAL REASON

Please provide the primary diagnosis / disability (e.g., Intellectual Disability, Cerebral Palsy, Multiple Sclerosis)

Is the primary contact for the first appointment the same as the referrer listed above? ◯ Yes ◯ No

Please list the people that are authorised to receive/sign the service agreement and information regarding services.

Note: if you are completing this form on the behalf of the participant, please seek approval from the participant prior to completing this section. If you are a support coordinator and have consent from the participant to receive the service agreement please enter your details below.

Name

Phone

Email

Organisation

Please note: Participants can withdraw this consent anytime by emailing marni@holisticspeechpathology.com.au

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GP CONTACT DETAILS

Name of Organisation

First Name Last Name

Email Phone

Please provide details of any support services in place:

REFERRAL REASON

- ◯ INITIAL ASSESSMENT
- ◯ THERAPY SERVICES
- ◯ NDIS PRE-PLANNING OR PROGRESS ASSESSMENT
- ◯ DYSPHAGIA / SWALLOW ASSESSMENT
- ◯ AAC: AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

ADDITIONAL INFORMATION

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SERVICES AND NDIS FUNDING

NDIS funding please confirm the funding available or hours of service required for the speech pathology supports requested.

Preferred Delivery of Services?

- ◯ Community - local park, library room etc
- ◯ Home
- ◯ School/ Daycare
- ◯ Other - Please specify below
- ◯ Workplace

PAYMENT

How is the plan managed?

- ◯ Self managed
- ◯ Plan managed

Note: Holistic Speech Pathology requests that you note us as a **My Provider** in the PACE portal. *This is a requirement for all Plan Managed participants.*

NOTE: The invoices will be sent to the person listed below. You are required to pay Holistic Speech Pathology's invoice in full within 7 days.

Name

Name of Organisation (if applicable)

Phone

Email

Cancellation and non attendance policy:

You may be charged a short notice cancellation fee where you do not provide at least two (2) clear business days' cancellation notice for your agreed speech pathology service. The therapist may charge up to 100% of the expected costs for the assessment/therapy and travel time.

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SAFETY

In order to proceed with your referral all questions must be answered as we provide services in the home environment.

Is anyone at your/the client's property, known to be aggressive or violent?	yes/no? if yes, details:
Does anyone at your/the clients property have a criminal history?	yes/no? if yes, details:
Is there a history of drugs or alcohol misuse at the property?	yes/no? if yes, details:
Are there any firearms being stored at the property?	yes/no? if yes, details:
Does the client have a positive behaviour support plan in place?	yes/no? if yes, details:
Are there any pets at the premises?	yes/no? if yes, details:
Are there any other factors we should be aware of?	yes/no? if yes, details:

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TO COMPLETE THIS REFERRAL FORM SIGN & RETURN

Please return completed form to:
marni@holisticspeechpathology.com.au

Person completing this form:

Please insert your name, sign and date to authorise Holistic Speech Pathology services to commence, based on the information provided in this form.

Print Name:

Signature:

Date: