MPOT™ ACCESS FITNESS We support the ndis

Occupational Therapy - Speech Pathology - Physiotherapy - Exercise Physiology

NDIS - Motor Vehicle Claims - Return to Work - Private Health - Medicare - Home Care Packages - Medico-Legal

NDIS - NEW REFERRAL

Person Completing Form:* Date: *

Please provide contact number or email if you are not the referrer.

PART A – PARTICIPANT INFORMATION

NDIS Participant Number: *

NDIS Plan Dates: Start: / / Finish: / /

CONTACT DETAILS

Mr/Mrs/Miss/Ms/Dr/Mx/Non-Binary: **Date of Birth:** *

First/Given Name(s): * **Last/Family Name:** *

Phone/Mobile: * **Email:**

Address: *

Suburb: * **Post Code:**

Are you of Aboriginal or Torres Strait Island origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

COMMUNICATION DETAILS

Preferred Contact Method: * ☐ Phone ☐ Email ☐ Text

Translator Required? * ☐ No ☐ Yes Language:

Preferred method of receiving letters, reports, documents (including initial NDIS Client information pack): *

☐ Post ☐ Email Please provide details if different from above:

PART B – PARENT / CARER INFORMATION

Participant gives permission to contact? ☐ **Y** ☐ **N**

Relationship to client: *

Mr/Mrs/Miss/Ms/Dr/Mx:

First / Given Name(s): * **Last / Family Name:** *

Phone / Mobile: * **Email:**

Address (If Different to Participant):

PART C – PLANNER / REFERRER / OTHER

Participant gives permission to contact? ☐ **Y** ☐ **N**

Relationship to Client: *			
Mr/Mrs/Miss/Ms/Dr/Mx:			
First / Given Name(s): *		**Last / Family Name:** *	
Phone / Mobile: *		**Email:** *	
Organisation:			

PART D – NDIS PARTICIPANTS FUNDING DETAILS*

☐ Participant Self-Managed Funding

☐ Participant Funding Managed by NDIA (National Disability Insurance Agency)

☐ Participant Nominated Registered Plan Management Provider

(Please provide ALL details below of your Plan Manager) *

Contact Name:

Organisation:

Phone Number:

Email Address:

SUPPORT AREA	AVAILABLE FUNDING
☐ Improved Daily Living	
☐ Improved Health & Wellbeing	
☐ Coordination of Supports	

PART E – DETAILS OF REFERRAL

Referral Type: *

☐ Physiotherapy ☐ Occupational Therapy ☐ Exercise Physiology

☐ Speech Pathology ☐ Driving Assessment ☐ Allied Health Assistant

****Learner's Permit Required** ****As directed by Therapist**

MPOT/Access Fitness Participants can choose one or more services within MPOT/Access Fitness. Participants are free seek services from other Providers.

Reason for Referral / What is the Request: *

Current Equipment:

Diagnosis/Condition:

Other comments:

DISABILITY (TICK ONE OR MORE IF KNOWN):

- ☐ Sensory. Details:
- ☐ Physical. Details:
- ☐ Cognitive / Acquired Brain Injury. Details:
- ☐ Other (please note details):

DRIVER ASSESSMENT DETAILS:

NOTE: Please complete only if referring for an Occupational Therapist Driver Assessment

Driver's Licence held? * ☐ Yes ☐ No **If YES, Type:**

Car transmission you drive: * ☐ Auto ☐ Manual **Expiry:**

Preferred location of assessment: * ☐ MPOT Office ☐ Home

Any specific car modifications or hand controls required? (if yes please detail below) ☐ Yes ☐ No

Details:

HOW DID YOU HEAR ABOUT MPOT/ACCESS FITNESS?

- ☐ **Friends/Family**
- ☐ **Another Client**
- ☐ **Health Professional**
- ☐ **Support Coordinator**
- ☐ **NDIS**
- ☐ **Referral Capacity Email**
- ☐ **Other:** _____

WE RECOMMEND THIS FORM BE SAVED FOR YOUR OWN RECORDS.
EMAIL FORM AS PDF TO **referrals@mpot.com.au**

MPOT/Access Fitness would like to provide the best possible service, please complete all details in the above form ensuring the areas highlighted with a red asterisk (*) are completed.