

MAKE A REFERRAL

Authorised Representative Information

First name

Last name

Phone number

▼

Email

Relationship to Participant:

☐ Coordinator

☐ Parent

☐ Legal Guardian

☐

Participant Information *

First name *

Middle name

Last name *

Preferred name title

Date of birth

▼

▼

▼

Sex

▼

Gender identity ⓘ

▼

NDIS number *

Participant/ Nominee Email ***Participant or Nominee Contact *****Address**

Address

City/Town

State/Region

Postal/Zip code

Country

**Diagnosis *****Which Service(s) are you requiring?**☐ Positive Behaviour Support**Briefly describe reason for referral / behaviours / treatment goals****Does the participant pose a risk to our workers? If so, please specify.**

Is the home environment safe for face to face visits? Please specify if not.

Does the participant use alcohol or other drugs? If so, please specify.

Practitioner preference

Is Telehealth an option? *

☐ Yes ☐ No

Plan start date

 

Plan end date

 

Fund management

 

Funds available to Care Garden Therapy in this service agreement for the provision of service per the terms above

BSP Specialist Budget (if applicable)

BSP Training Budget (if applicable)

Is the participant on the PACE system and if so who should we contact for endorsement?

Where did you hear about us?

☐ Word of Mouth

☐ Google☐ Email☐ LinkedIn**Today's Date**

Upon submitting the form, your personal details will be sent securely to Care Garden Therapy. Please review and accept the privacy policy of Care Garden Therapy and click I reviewed and I accept.

☐ I reviewed and I accept