WHR Allied Health Referral Form

WHR ALLIED HEALTH
BARWON - OVENS & MURRAY - MURRUMBIDGEE

Referral Process		
To refer a client to WHR Allied Health, please complete this form and submit it via: • **Email:** admin@whralliedhealth.com • **Phone:** 0431 556 720 • **Online:** WHR Allied Health Referral Form – Fill in form **Consent Requirement:** Ensure you have obtained consent from the client or their legal representative before submitting this referral. **Response Time:** We will contact you within 48 hours of receiving the referral.		
Referrer Information		
Referrer Name:		
Referrer Phone:		
Referrer Email:		
Client Information		
Client's Full Legal Name:		
Preferred Name:		
Gender Identity: (She/Her, He/Him, They/Them, Other [Please specify])		
Cultural Identity: (Optional, the client may have different needs but will have the same rights and can expect the high standard of service)		
Contact Information		
Address:		
Date of Birth: (DD/MM/YYYY)		
Email:		
Phone:		
If a representative is acting on behalf of the client, please provide:		
Representative's Name:		
Relationship to Client:		
Phone:		
Email:		
☐ Contact for Arranging Appointments	☐ Contact for signature on Service Agreement	☐ Emergency contact
Alternative Contact Name:		
Relationship to Client:		
Alternative Contact Phone:		
Alternative Contact Email:		

WHR ALLIED HEALTH
WORK HEALTH REHAB GROUP PTY LTD
ACN: 662 543 115
ABN: 49 662 543 115

whralliedhealth.com | 0431 556 720
PO Box 895 | Torquay VIC 3228
PO Box 993 | Albury NSW 2640

Please use the space below to include details for any other relevant contacts:	
Are you transitioning from another service provider? *If 'Yes', please provide details about your current provider and the reason for transition.*	
Strengths and Interests	
WHR Allied Health uses a strengths-based approach. In the therapeutic process, it is helpful for us to know what the person enjoys doing or does well.	1. 2. 3.
Medical and Support Information	
Disability/Diagnosis Information: To ensure we allocate a suitable therapist, please provide details about the client's disability, any assistive technology or equipment they use, and the specific reasons for seeking support from WHR Allied Health.	
Safety Considerations	
Are there any **Court Orders** (e.g. Family Court Orders, Apprehended Violence Orders, Family Violence Orders), or any **history of assault or harassment charges**, relating to the person seeking supports or anyone residing in or frequently visiting the home, that we should be aware of for the purpose of appropriately allocating an Occupational Therapist with relevant experience and training?	

Budget and Service Management

Private / Medicare fee-paying (if applicable):	
Medicare Details:	
Medicare Number:	
Position on Card:	

Primary goals for seeing OT: (please tick all that apply)

☐ Face-to-face therapy

☐ Seeking support to obtain a diagnosis

☐ Recommendations and strategies to use at home/school to better support the client

☐ Other (Please describe):_____

NDIS Plan (if applicable):	
NDIS Number:	
Plan Start Date: (DD/MM/YYYY)	
Plan End Date: (DD/MM/YYYY)	
NDIS Plan Goals: Describe the goals set in the NDIS plan that this referral aims to address.	

How will invoices be managed?

☐ Self-managed

☐ NDIA managed

☐ Fund Management Provider (FMP Name: _____)

Please specify your budget allocation for WHR Allied Health supports:

Flexible Support Budget Total:	
OR	
Occupational Therapy Budget:	
Therapy Assistant Budget:	
Physiotherapy Budget:	

Is funding available in your NDIS Plan under 'Improved Daily Living'?	☐ Yes ☐ No *If not, you will need to be either self/plan managed to claim OT supports. Alternatively, you can self-fund WHR Allied Health supports*