



## Referral Form

Once form has been completed, please email to [panania@bchpt.com](mailto:panania@bchpt.com)

### 1. Type of Support Required (X all relevant items)

Exercise Physiology Consultations (1:1)	
Exercise Physiology Group Glasses	
Exercise Physiology - Hydrotherapy	
Exercise Physiology - Home Visit	

### 2. Client Details

Full Name			
Preferred Name			
Client NDIS Number			
Date of Birth			
Gender			
Address			
City			
State	Postcode		
Contact Number (if appropriate)			
Email Address (if appropriate)			
Communication for organising sessions	Best through Client: Parent: Support staff: (If parent or support staff, please provide phone number and email address below)		
	Phone:		

	Email:
--	--------

### 3. NDIS Plan Details

Proposed Service Start Date			
NDIS Plan Start Date			
NDIS Plan End Date			
How is the Plan Managed? (NDIA/Plan/Self-Managed)			
Plan Manager/Self-Manager Details (if Different from Consent Person)			
Funding available in NDIS Plan for this support			
Possible item codes			
Support Category	NDIS Line Item	Hours	\$ Value
Core Supports			
Capacity Building Supports			

### 4. Client Carer / Guardian Details

Full Name	
Relationship to Client	
Address Line 1	
Address Line 2	
Contact Number	
Email Address	

### 5. Client Additional Details

Risks / Behavioural concerns to note	
Ethnicity	
Language spoken at home	
Living arrangement	
Medical practitioner details	Name: Practice: Contact information:
Medical Conditions:	
Symptoms of Condition:	
Treatment Methods:	
Relevant Medical Practitioner:	
Medical Condition:	
Symptoms of Condition:	
Treatment Methods:	

### 6. Referral Consent

Consent for referral gained?	
Name of consenter	
Date of consent	
Name of referrer	
Organisation (if applicable)	
Position	
Contact number	
Contact email	
Background information reason for referral/ any urgent requests  Please briefly explain the main goal to be achieved through the referral	