Iconic care PTY LT
02 4604 8282 - 0474 801 695
www.iconiccaregroup.com.au
Info@iconiccaregroup.com.au

NDIS / Allied Health Referral Form

Form completed by:		**Date completed:**	

Referral details			
Legal First name:		Legal Surname:	
Preferred name:	Date of birth:	Gender:	Pronouns:
I am a: (please select what applies)	☐ NDIS Participant ☐ Parent ☐ Support Person ☐ Plan Manager ☐ LAC/Support Coordinator ☐ Other – Specify:		
Culture: (Select all apply)	☐ Aboriginal	☐ Torres Strait Islander	☐ Other (Please specify)
Address:		Phone:	
Suburb:	Postcode:	Email:	
Guardian/Carer Details:	☐ Parent ☐ Carer ☐ Guardian ☐ Other:		
Name:		Preferred contact: ☐ Phone ☐ Email ☐ Both	
Phone:	Email:		
Other Contacts: E.g. Support coordinator, Team leaders, Guardian address			

Consent – contact using information on this form to arrange appointments or more information	
Provided by:	Date:
☐ Verbal consent ☐ Written Consent (attach to this form)	☐ Consent to SMS ☐ Consent to Email

Do you need Communication assistance? E.g. Interpreter, Communication device	☐ Yes *(Please describe)* ☐ No
Diagnosis:	
Current Supports:	

Services Requesting	☐ Occupational Therapy ☐ Speech Pathology ☐ Psychology ☐ Counselling ☐ Dietetics ☐ Social work *NDIS: Requires Improved In Plan*	☐ Behaviour Support ☐ Exercise Physiology *NDIS: Requires Improved Relationships in Plan*	☐ Coordination of Supports ☐ Specialist Support Coordination *NDIS: Requires Support Coordination in Plan*
Service preference	☐ Face-to-face ☐ Teleheath ☐ Either / Both		

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Participant legal name:	

Funding Information:	☐ NDIS *(add info below)*	☐ Private Paying ☐ Medicare ☐ PHN – School / Preschool *(go to "service request" details)*
	Participant NDIS Number:	
	NDIS Plan Start Date:	**NDIS Plan End Date:**
	☐ Agency Managed ☐ Plan Managed (see below) ☐ Self-Managed *(see below)*	
	Plan / Self-Managed Details:	
	Send invoices to:	
	Email:	
	Phone:	
	Funding / Hours Available: Appropriate NDIS category available *(see services request)*	

Service Request Details	Is telehealth an option for all or part of the service? e.g. video link, phone call ☐ Yes ☐ No
NDIS Goals: What are thee relevant Goals on the NDIS Plan? *(if applicable)*	
Reason for this referral: ☐ Assessment (short-term support) ☐ Intervention/Therapy ☐ Unsure Details: *(Include why want to see children, participant needs, strengths, like/dislikes info about them)*	

Please save this document and submit it as an attachment to info@iconiccaregroup.com.au
Attach any additional information / documents as required.

Thank you for making a referral with our team! We look forward to continuing our support and helping others receive the care and assistance they need.