Montrose
Therapy & Respite Services

REFERRAL ENQUIRY

Referral for:

Date of Referral: ______________

- ☐ **Speech Pathology**
- ☐ **Physiotherapy**
- ☐ **Occupational Therapy**
- ☐ **Social Work**
- ☐ **Psychology**
- ☐ **Daily Living Support**

Short Stay Accommodation

First Name:

Person's details:

Surname: ______________ First Name: ______________ Date of Birth: ______________

Address: ______________

Primary Phone Number: ______________ Secondary Phone Number: ______________

Email: ______________

Condition/Diagnosis: ______________

____

____

Customer/Parent/Guardian Name/s and contact details if applicable: ______________

____

Has customer/parent's permission been obtained to make this referral? ☐ Yes ☐ No

Does the customer have any funding?

☐ Don't know, or

☐ NDIS:
- ☐ Self-managed
- ☐ NDIA managed
- ☐ 3rd party managed

(if yes, provide contact details below)

☐ Disability Services:
- ☐ Eligible / ☐ May be eligible for block funded services
- ☐ Individual Package (incl. YLYC)

☐ Helping Children with Autism (HCWA)

☐ Better Start

☐ Medicare Items:
- ☐ Chronic Disease Management Plan
- ☐ Better Start (7-15 yrs)
- ☐ Mental Health Care Plan
- ☐ HCWA (7-15 yrs)

☐ Private Health Insurance

☐ Self-funded

Will the customer be NDIS/DS eligible if no other funding? ☐ Yes ☐ No

NDIS Plan 3rd Party contact details: ______________

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Additional Information Main Goals (attach additional notes and reports if possible)

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School/Educational setting (if applicable)

Name of School: ____

Address of School: ____

____

School Contact Person: ____________________ Phone Number: ____________________

Has child been verified under Education Adjustment Program? ☐ Yes ☐ No ☐ Unsure

Details of Referral Source

Name: ____________________ Position: ____________________

Organisation: ____

Contact Details: ____

Email: ____

Please view our privacy statement available on our website.

Please return to:

Montrose Therapy and Respite Services
PO Box 3075
Darra QLD 4076

Referral Received (Office use only)

Date Received:	Received By: