Montrose
Therapy & Respite Services

REFERRAL ENQUIRY

Referral for:

Date of Referral: _____

- ☐ Speech Pathology
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Social Work
- ☐ Lifestyle & Leisure
- ☐ Short Stay Accommodation

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)

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: