ACTIVE PERFORMANCE
PO Box 200
Cairns North QLD 4870
admin@activeperformance.com.au
www.activeperformance.com.au

REFERRAL FORM

Referral Date: ______________

CLIENT DETAILS		
FULL NAME		
DATE OF BIRTH		
GENDER		
ARE YOU OF ABORIGINAL AND/OR TS ISLANDER ORIGIN?	Yes	No
ADDRESS		
PHONE		
EMAIL		
PREFERRED CONTACT	Email	Phone
LIVING ARRANGEMENTS	With Family/Caregiver Shared Accommodation	Alone Full-time live-in Supports

CLIENT'S REPRESENTATIVE/NOMINEE			
NAME OF PARENT/GUARDIAN			
RELATIONSHIP TO CLIENT			
PRIMARY CAREGIVER		Yes	No
LIVES WITH CLIENT		Yes	No
EMAIL	If different to above :		
PHONE	If different to above :		
PREFERRED CONTACT	If different to above :	Email	Phone

ALTERNATIVE CLIENT CONTACTS	
SUPPORT COORDINATOR	Name and Organisation Email and Phone
SUPPORT WORKER	Name and Organisation Email and Phone

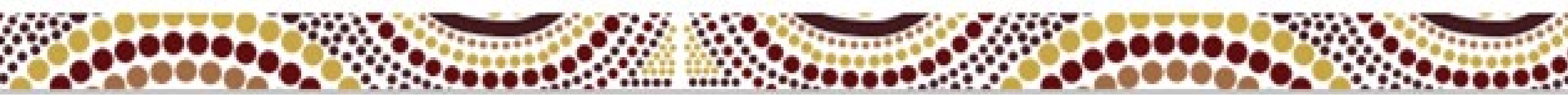
Active Performance would like to acknowledge the First Peoples who are the Traditional Custodians of lands on which we live and work; and would also like to pay respect to our Elders both past and present; and extend that respect to our clients and colleagues.

COMMUNICATION	
Who is the best contact to arrange appointments?	(Eg: Client, Client's representative, Support Coordinator)
Who is responsible for approving service agreements?	(Eg: Client, Client's representative, Support Coordinator)

NDIS PLAN & PAYMENT OF SERVICES	
NDIS PLAN NUMBER	
PLAN START DATE	
PLAN END DATE	
AGENCY MANAGED	
PLAN MANAGED	Name of Plan Manager: Email for Invoices:
SELF-MANAGED	Invoices addressed to: Email for Invoices:

MEDICAL DIAGNOSIS / PRESENTING CONDITIONS
Please provide as much detail as possible

Active Performance would like to acknowledge the First Peoples who are the Traditional Custodians of lands on which we live and work; and would also like to pay respect to our Elders both past and present; and extend that respect to our clients and colleagues.



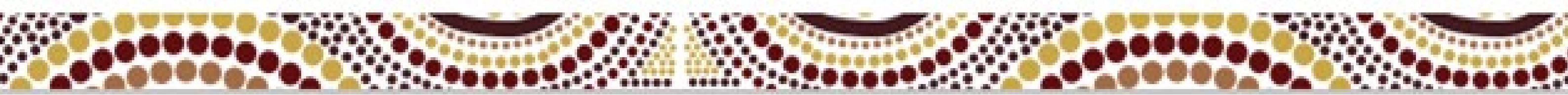
OTHER SERVICE PROVIDERS / SUPPORTS CURRENTLY ENGAGED	
Name / Organisation	
Phone / Email	
Name / Organisation	
Phone / Email	
Name / Organisation	
Phone / Email	
Name / Organisation	
Phone / Email	

INITIAL ASSESSMENT
Is a preliminary appt required to discuss any sensitive topics/issues, prior to meeting the client? NO YES Preferred place of Initial Assessment: IN-CLINIC HOME OTHER: Other people to be present for Initial Assessment (Eg: parent/caregiver, support worker, translator)

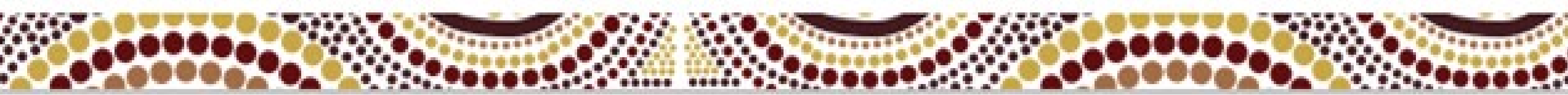
ONGOING SESSIONS (as required)
Preferred location for Ongoing Sessions IN-CLINIC HOME OTHER *Please note, we will do our best of accommodate preferences where possible but we cannot guarantee.*

APPOINTMENT PREFERENCES
Preferred days/times for appointments *Please note, we will do our best of accommodate preferences where possible but we cannot guarantee.*

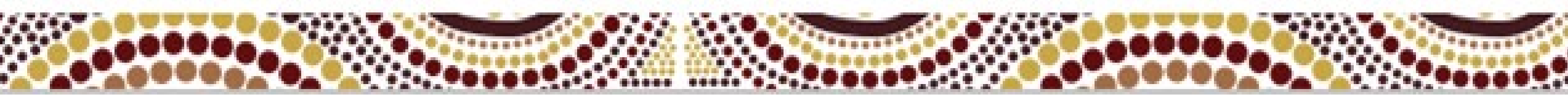
Active Performance would like to acknowledge the First Peoples who are the Traditional Custodians of lands on which we live and work; and would also like to pay respect to our Elders both past and present; and extend that respect to our clients and colleagues.



THERAPY SERVICES REQUIRED	
Physiotherapy	Budget available: .... Reason for this Request:
Occupational Therapy Functional Capacity Assessment & Report (FCA)	Budget available: .... Reason for this Request:
Occupational Therapy Assistive Technology Request – high cost/high risk (eg: scripted bed, wheelchair etc) **These items involve equipment trials, quotes and OT reports to NDIS.**	Does the client have budget for OT assessment? NO YES .... Does the client have budget for AT? NO YES .... Reason for this Request:
Occupational Therapy Assistive Technology Request – low cost/low risk (eg: shower chair)	Budget available: .... Reason for this Request:
Occupational Therapy Ongoing Therapy Sessions / Skills Building	Budget available: .... Reason for this Request:
Occupational Therapy Supported Independent Living/Specialist Disability Accom Assessment & Report (SIL/SDA)	Budget available: .... Reason for this Request:
Dietitian Services	Budget available: .... Reason for this Request:
Speech Therapy	Budget available: .... Reason for this Request:



HOME VISIT RISK ASSESSMENT		
To ensure the safety of our therapists entering the home, please complete this list accurately and entirely. Home appointments will not proceed without this assessment in place.		
Is there a history of behaviours with the client?	NO	YES: Aggression Violence Sexual Risk Self-Harm Hoarding Drug/Alcohol Abuse Other:
Will other people be present when the therapist visits?	NO	YES: If so, who?
Is anyone living at the premises known to be potentially aggressive or violent?	NO	YES: If so, who?
Are there firearms in the home?	NO	YES
Does the client live in an isolated area?	NO	YES
Are there any access issues onto the property? (Eg: pets, terrain, gate key)	NO	YES *Please have pets restrained at the time of visit*
Is there any difficulty with mobile phone coverage?	NO	YES
Is the client, or anyone on the premises, a smoker?	NO	YES
Does anyone at the property have an infectious disease and/or contagious illness?	NO	YES
Are there any other factors relating to the property or tenants that may be relevant to the safety of our therapists?	NO	YES



CLIENT REPORTS / ASSESSMENTS
I have attached with this referral: Goal Pages from the NDIS Plan Relevant Assessment/Reports from other service providers Formal medical diagnosis None of the above, please explain:

CONSENT
Name of the person completing this referral: Email of person completing this referral: Yes, I am authorised to submit this referral and share information about this client Client has consented to receiving these services

Please return this completed form and accompanying documents to

admin@activeperformance.com.au

Active Performance would like to acknowledge the First Peoples who are the Traditional Custodians of lands on which we live and work; and would also like to pay respect to our Elders both past and present; and extend that respect to our clients and colleagues.