Country Therapy

REFERRAL FORM FOR PAEDIATRIC MEDICARE PARTICIPANTS

1. PARTICIPANT DETAILS

First Name:	Last Name:
Date of Birth:	PH:
Gender:Male Female Other:	E:
Address: Suburb: State: Postcode:	
Alternative Contact: (Must be different from referrer details) Name: PH: Relationship: E:	
Medicare #: Number/position: Expiry:	*Please attach medicare referral*
Booking contact: If you wish to have more than one person contacted regarding bookings please list people persons:	
Name: PH: E:	Name: PH: E:

2. REFERRER DETAILS If you are referring yourself and move to **section 3**

Name of Organisation: (if applicable)	
First Name:	Last Name:
PH:	E:

Job Title/Role: Support Coordinator Case Manage Local Area Coordinator Family member Other:

3. Diagnosis:

4. School Information:

School/ Address:	
PH:	E:
Grade/Year:	Teacher & Contact (if applicable):

5. Security *(In order to proceed with your referral ALL questions **MUST** be answered.)*

Is anyone at your / the client's property, known to be aggressive, violent or with a criminal history ? If Y – please advise:	Y N
Does anyone at your/the clients property smoke? If Y – please advise:	Y N
Does the client have a positive behavioral support plan in place? If Y – please attach a copy of PBS	Y N
Is there a history of drugs or alcohol misuse at the property? If Y – please advise:	Y N
Are you aware of any firearms being stored at the property? If Y – please advise:	Y N
Are you aware of any occupant having an infectious disease? (i.e. chicken pox / shingles / gastro, etc.) If Y – please advise:	Y N
Do you have any pets at your premises?	Y N
Are there any other factors we should be aware of? If YES, please describe:	Y N

6. Accounts Information :

Who is responsible for paying the account / invoice? (please select one)

Plan Managed - Organisation Name:
Self-Managed

For Plan Manager or Self Managed, please complete the following details: Name of person responsible for the account:
Phone:
Email:

7. Reason for Referral/Concerns: (Please describe support required)