

NDIS Participant Referral & Intake Form

Thank you for considering PX Therapies. Please complete the relevant fields below and email the completed form to pxtherapies@gmail.com. Fields marked with an asterisk (*) are essential to process the referral. Please attach a copy of the participant's current NDIS plan and any relevant clinical reports.

1. REFERRAL SOURCE

Support Coordinator name *	Date of referral *
Organisation *	SC level (1 / 2 / 3) *
Phone *	Email *

2. PARTICIPANT IDENTITY

Full legal name *			Preferred name
Date of birth *	Age *	Sex	NDIS number *
Residential address *			
Suburb *	Postcode *	Lives with	
Participant phone	Participant email		
Primary language spoken at home	Interpreter required?		
	☐ Yes ☐ No		

3. PRIMARY CONTACT (IF NOT THE PARTICIPANT — E.G. PARENT, GUARDIAN, PARTNER)

Name	Relationship to participant
Phone	Email
Can the OT contact the participant directly?	☐ Yes — direct contact OK ☐ No — via this contact only

4. NDIS PLAN DETAILS

Plan start date * Plan end date * Reassessment due

Plan management *
☐ Self-managed ☐ Plan-managed ☐ NDIA-managed ☐ Mixed

Plan manager name & contact (if applicable)

OT funding available — which category? *
☐ CB Daily Living (Improved Daily Living) ☐ CB Social & Community
☐ Core — Daily Activities ☐ CB Relationships (BSP)
☐ Capital — AT (note: PX Therapies does not provide AT)

Approximate OT funding remaining (\$ or hours) Stated supports? (Y/N + details)

5. DIAGNOSES & DISABILITY

Primary disability / diagnosis *

Secondary diagnoses / co-morbidities

Brief functional impact summary (a few lines is plenty — full clinical detail not required at intake)

6. REASON FOR REFERRAL

What is required? (tick all that apply) *
☐ FCA — NDIS plan reassessment ☐ FCA — Change in Circumstances
☐ FCA — AAT review / appeal ☐ Ongoing OT therapy
☐ Capacity building (specific skill area) ☐ Home assessment / safety
☐ Transition planning (school / adult) ☐ Support worker training
☐ Other (specify below)

Other / specific details about the referral request

Urgency * ☐ Routine ☐ Priority ☐ Urgent Deadline / due date

If urgent, reason / context

7. CURRENT SERVICES & PROVIDERS

Existing OT (if transitioning from another provider)

Other allied health currently engaged (psychology, speech, physio, dietitian, etc.)

Support workers in place

Behaviour support practitioner

Other relevant treating clinicians (GP, paediatrician, psychiatrist, specialist)

8. RISK & SAFETY — PLEASE COMPLETE HONESTLY TO ENSURE SAFE SERVICE DELIVERY

Known risks (tick all that apply, then describe below)

- ☐ Behaviours of concern
 ☐ Mental health concerns
 ☐ Self-harm / suicidality history
☐ Family / domestic violence concerns
 ☐ Isolation / no informal supports
☐ Dwelling concerns (hoarding, unsafe environment)
 ☐ Substance use
☐ No known risks

Detail any ticked risks (essential for clinician safety planning) *

Any specific risks to a clinician attending the home?

Restrictive practices in place?

☐ Yes

☐ No

If yes, brief detail

9. PRACTICAL ACCESS & PREFERENCES

Preferred contact method

☐ Phone

☐ Email

☐ SMS

Best time

Service delivery preference

☐ Home visits

☐ Community

☐ Clinic

☐ School

Access requirements (e.g. interpreter, second clinician for safety, accessible parking)

10. DOCUMENTS SUPPLIED WITH THIS REFERRAL

- ☐ Current NDIS plan
 ☐ Previous OT / allied health reports
 ☐ Diagnostic letter
☐ Behaviour support plan
 ☐ Hospital discharge summary
 ☐ Other (specify)

Other documents

11. SUPPORT COORDINATOR SIGN-OFF

☐ I confirm consent has been obtained from the participant / guardian to share these details with PX Therapies.

Signature (typed name accepted) *

Date *

Please email the completed form, NDIS plan, and any supporting documents to pxtherapies@gmail.com.

PX Therapies will acknowledge receipt within 2 business days and confirm acceptance of the referral.

PX Therapies | pxtherapies@gmail.com

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