Allied Health Referral Form

We Care New South Wales

Date completed: _ _ /_ _ / _ _ _ _

Return via email to reception@wecarensw.com.au

or mail to 1/500 High Street, Maitland NSW 2320

PLEASE NOTE — all relevant sections of this referral form must be completed before the client can be allocated to a clinician.

Client Being Referred

Legal Name: _____ Surname: _____

Any other names: _____

Date of Birth: _ _ /_ _ / _ _ _ _ Age: _____ Gender: _____

Email Address: _____ Phone Number: _____

Client Address and Other Details

Street Address: _____ Suburb: _____ Postcode: _____

Preferred We Care NSW office: ☐ Broadmeadow ☐ Maitland

Which days are you available for ongoing appointments? _____

Does the client identify as: ☐ Aboriginal ☐ Torres Strait Islander Nation: _____

Other cultural and linguistic diversity: _____

Aboriginal Consultant required: ☐ Male ☐ Female ☐ N/A

Interpreter required: ☐ Yes ☐ No

If yes, what language? _____

Referrer Details

Name: _____ Organisation: _____

Position: _____ Address: _____

Email: _____ Contact Number: _____

Has this referral been discussed with the client? ☐ Yes ☐ No

Can the client be contacted directly regarding this referral? ☐ Yes ☐ No

Guardian or Person Responsible - *Who will sign the Service Agreement?*

Name: _____ Contact Number: _____

Address: _____ Email: _____

Relationship to client: _____

REASON FOR REFERRAL

Please list any current diagnoses and provide information about the main issues or concerns for the client:

What outcomes are you hoping We Care NSW will achieve for this client?

Please list any other Allied Health Professionals involved:

RISK ASSESSMENT – *please complete this section to help us identify which clinician will be best suited to this referral.*

Please outline any concerns you have regarding risk of harm to self or others:

Phone 02 4013 6079 **Fax** 02 4058 1079
Email reception@wecarensw.com.au
Website wecarensw.com.au

Office 1 50 Church St, Maitland 2320
Office 2 1/500 High St, Maitland 2320
Office 3 4/33 Newton St, Broadmeadow 2292
Office 4 Suite 10, Wharf Central 75-77 Wharf St, Tweed Heads 2248

We Care
New South Wales

☐ **NDIS** – please attach your NDIS plan and complete the fields below:

NDIS Number: _____

Plan Start and End Date: _____

Claiming Details: ☐ Plan Managed ☐ Self-Managed ☐ We Care NSW via Portal

Invoices to be sent to: _____

Funding Type: ☐ **Improved Relationships** Funding Amount: $_____

☐ **Improved Relationships - Specialist** Funding Amount: $_____

Are any Restrictive Practices in place? _____

☐ **Improved Daily Living** - Psychology Funding Amount: $_____

- Speech Therapy Funding Amount: $_____

☐ **Medicare** – *please attach your Mental Health Care Plan and referral letter from your GP*

Medicare Number: __ __ __ __ __ __ __ __ __ __

Position on Card: __

Expiry Date: __ __ __

☐ **Fee for Service (including FACS/DCJ, other third parties)** - you will be contacted by We Care NSW with further information of the cost associated with assessments and other services.

Please indicate where invoices should be sent to in the box below:

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Website wecarensw.com.au

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