

**Koros Health Care Referral Form**

Please fill out the form below and return it to **kap@koroshealth.com.au** All fields marked with \* are required. Please note there are two pages.

Participant Name\*:

Participant Date of Birth\*:

Participant Contact Number\*:

Participant email\*:

Participant address\*:

NDIS number\*:

Plan Start Date\*:

Plan End date\*:

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| --- |
| NDIS Funding for Capacity Building Budget\*:  Agency  Plan  Self Managed  If plan managed please provide details of plan manager\*: |

Disability /Diagnosis\*:

|  |
| --- |
| Reason for referral\*:  Functional Capacity Assessment  Initial Occupational Therapy Assessment  Equipment  Therapy  Housing and Accommodation (SDA/ SIL/ ILO)  Other (please specify below) |

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NDIS Plan Goals:

Short Term:

Medium/Long term:

Preferred Contact (if not participant):

Will any support persons be with the participant at the initial appointment?

How do we safely access the participants property? \*

i.e. Are there any safety risks for the visit?

Are there stairs /locked gates/ pets?

If appropriate, is the participant agreeable to remote services during COVID 19 ?

Yes

No

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