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*:

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)

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 ?

- [x] Yes
- [ ] No