WILL & WAY THERAPY SERVICES PTY LTD
ABN 63 626 666 797
P: 0421 518 609
0450 249 171
E: info@willandway.com.au

REFERRAL FORM

DATE:

The client has provided consent to share the below details and engage with Will & Way Therapy Services.
☐ **(please check box)**

Client Details			
Name		**Date of birth**	
Language		**Interpreter required?**	Yes ☐ / No ☐
Phone Number		**Email address**	
Home address		**Postal address (if different)**	
Next of kin	Name: Relationship: Phone number:		
Preferred contact method	Phone call ☐	Text message ☐	Email ☐
Preferred appointment times/availability			

Funding Type

National Disability Insurance Scheme (NDIS)		
Participant number		
Plan dates	to	
NDIS plan goals		
NDIS plan attached?	No ☐ Yes ☐	
Funding management type	Agency managed ☐	Plan managed ☐ Self-managed ☐
NDIS Contact	Name: Phone:	Role: Email:
Plan manager details (if applicable)	Name: Agency:	Phone: Email:
Support coordinator details (if applicable)	Name: Agency:	Phone: Email:

Self-funded	
Preferred Payment Method	
Will you be seeking a Medicare rebate?	No ☐ Yes ☐ Medicare card number: Expiry date: Account details for direct deposit rebate: Account Name – BSB – Account Number –

Home Care Package		
Type of package/ package level		
Case manager details	Name: Agency: Availability:	Phone: Email:

Transport Accident Commission (TAC)		
Claim number		
Disability relating to claim		
Date of accident		
Claim manager details	Name: Availability:	Phone: Email:

WorkSafe		
Claim number		
File number		
Disability relating to claim (if applicable)		
Claim manager details	Name: Availability:	Phone: Email:

Service Type

Service Request Details	
Referral source	**How did you hear about Will & Way Therapy Services?** Website ☐ Google ☐ Friend or colleague ☐ Other?
Client diagnosis / disability	
Relevant past medical history	
Service required	
Allocated funds for service (if known)	$
	If the client is NDIS funded and needs support for assistive technology prescription, are the required items noted in their current plan? Yes / No
Any additional details	Does the client have any cultural or religious requirements that Will & Way Therapy Services staff should be aware of? Yes ☐ / No ☐ **Details:** Are there any potential safety risks that staff should be aware of (i.e. instances of aggression towards service providers by the client or their friends/family members, concerns about home environment, substance abuse, dangerous animals, etc.)? Yes ☐ / No ☐ **Details:**

Referrer Details			
Name		**Role**	
Phone Number		**Email**	
Organisation			
Signature	X_____		

*****PLEASE EMAIL COMPLETED REFERRAL FORM TO info@willandway.com.au*****