DESERT THERAPY

DESERT THERAPY - Referral Form for NDIS Participants

Please forward referral form to referrals@deserttherapy.com.au

Client information:			
Referral Date:			
Name:		**DOB:**	
Address:		**Phone:**	
Main Contact/ Next of Kin:	**Name:** **Relationship:** Phone:	**Secondary Contact:**	
Gender:	☐ Male ☐ Female ☐ Other:		
Communication Needs:	**Interpreter Required: Yes** ☐ **No** ☐ **Language Spoken:**		
NDIS plan:	Start date: End date:	**NDIS #:**	
Please Attach Copy of NDIS Plan and percentage allocated to Desert Therapy Services			
Care of:	☐ Territory Families ☐ OPG Other/Details:		
Behavioural and Risk Notice	☐ Criminal History: ☐ Drug/Alcohol history: ☐ Aggression ☐ Absconding ☐ Other:		
Plan Managed ☐ **Agency Managed** ☐ **Self-Managed** ☐ **If Plan or Self-Managed **Name:** **Email:**			
School Detail		**Phone:**	
Doctors Name:		**Phone:**	

Referring Agency/Person/COS:			
Name:		**Relationship/Agency:**	
Email:		**Phone number:**	

Additional Referral Information:

Reason for Referral:

Disability / Diagnosis (please include diagnosis and medical information and attach relevant documentation):

NDIS Participant Goals (please list or attach the plan):

Current service providers involved:

DESERT THERAPY ABN 59 630 016 330
LOCATION: 4/1 Colson Street, Alice Springs NT 0870
PHONE: 08 8960 5905
POSTAL ADDRESS: PO Box 4274, Alice Springs NT 0870
EMAIL: admin@deserttherapy.com.au | WEBSITE: www.deserttherapy.com.au

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DESERT THERAPY

Services you wish to engage

☐ SPEECH PATHOLOGY

Assessment and Report ONLY	☐	*Assessment and ongoing therapy*	☐
Verbal	☐	Non-verbal	☐
Difficulty Speaking, listening, and understanding	☐	Dysphagia Management: difficulty eating, drinking, and swallowing food and fluids	☐
SOS feeding therapy	☐	Telehealth (for non-ASP based referrals)	☐
Already on a modified diet:		YES ☐ No	☐

Other: (please list)

☐ OCCUPATIONAL THERAPY

Assessment and Report ONLY	☐	*Assessment and ongoing therapy*	☐		☐
Developmental Assessment	☐	Sensory Assessment	☐	Driving Assessment	☐
Equipment Prescription	☐	Home Assessment	☐	Home Assessment	☐
Functional Assessment	☐	Wheelchair Assessment	☐	Care Needs Assessment	
Other	☐	Manual handling / Transfer Assessment			☐

☐ PHYSIOTHERAPY

Assessment and Report ONLY	☐	*Assessment and ongoing therapy*	☐		☐
Falls assessment and prevention	☐	Gross motor skills	☐	Hydrotherapy	☐
One on One Exercise sessions	☐	Gait Training	☐	Mobility Assessment	☐
Pain Management	☐	Exercise Prescription	☐	Weight Management	☐
Equipment Prescription	☐	Other:			

☐ EXERCISE PHYSIOLOGY

Assessment and Report ONLY	☐	*Assessment and ongoing therapy*	☐

Permanent Disability/Impairment requiring EP:
Other relevant medical/ Musculo-skeletal conditions:

Reason for referral

Obesity	☐	Neurological	☐	Deconditioning	☐
Chronic disease Management	☐	Spinal Cord	☐	Hydrotherapy	☐
Maintain/improve specific activities	☐	Mobility Assessment	☐	Weight Management	☐
Balance exercises/falls prevention	☐	Maintain/improve mobility	☐	Improve stamina strength	☐
Gain higher level of independence	☐	Improve health and wellbeing	☐	Build capacity for daily living	☐

Other:

Preferred or requested way to exercise

Water based activities	☐	Walking	☐	In clinic setting	☐
Community settings	☐	In Gym setting	☐	In home setting	☐

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