**Persons details**

|  |  |  |
| --- | --- | --- |
| First Name: | Last Name: | Date of Birth: |
| Contact Phone Number: |  |  |
| Type of Residence:  Private Home  Residential Care  Other: | Preferred Language:  Interpreter required?  Yes  No | |
| Address: | | |
| NOK of Kin or nominated person:  Contact details:  Is this person to be contacted for the purposes of the appointment?  Yes  No | | |

**Referrer Details:**  Check box if you are referring yourself

|  |  |
| --- | --- |
| Name: | Organisation: |
| Job Title:  HCP Provider/ CHSP  Residential Care Facility  Family: | Email: |
| Phone contact: |

**Reason for Referral:**

|  |
| --- |
| **I want an assessment to review:** |
| **Relevant Information:** |
| **Hourly service rate: (per hour) Please tick the required option.**  $135.00 + GST per hour  Initial Assessment - Minimum 2 hours: which includes an assessment within the living environment, a brief report and travel up to 30mins. = 2 hrs total  Repeat/follow up assessment-minimum 45 mins plus up to 30 mins travel = 1hr 15 mins  No Report - Minimum 1 hour initial appointment, plus up to 30 mins travel = 1.5hr |
| **Invoice to be paid by**  **please email my invoice to:**   * Name: * Email Address:   **please post my invoice to:**   * Name * Address:   I understand that terms of payment are within 14 days.  **Please note that cancellations fees may apply:**   * **Where an appointment is cancelled, or not attended without providing notice by 3pm the day prior to the agreed appointment time.** |

Please kindly send this completed referral form to to: [info@bepositivetherapy.com.au](mailto:info@bepositivetherpay.com.au) P: (03) 9112 5982

|  |  |
| --- | --- |
| Name: | Signature: |
| Date: |