**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 P: (03) 9112 5982

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