**Client details**

|  |  |  |
| --- | --- | --- |
| First Name: | Last Name: | Date of Birth: |
| Phone contact: | NDIS number (if applicable) | Preferred Language:  Interpreter required?  Yes  No |
| Address: | | |

**Legal Representative:**

|  |  |
| --- | --- |
| Name: | |
| Legal Firm: | Email: |
| Phone contact: |

**About the participant:**

|  |
| --- |
| **Disability:** |
| **Other relevant conditions:** |
| **Reason for referral:** |
| **Hourly service rate: (per hour)**  AAT (NDIS) - $193.99 (minimum 12 hours)  Non NDIS - $205.00 (minimum 15 hours) |
| **Letter of Instruction attached**  **Client is consenting to this referral**  **BePositive Allied Health Clinician requested: (name):**  **Other documents attached. Please list:** |
| **Invoice to be paid by**  **Client (please list contact email for invoice):**  **Legal Representative (please list contact details for invoice):**  **Other (please provide details for invoice):** |

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

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