liveBetter
community services

LiveBetter Hunter & Central Coast
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livebetter.org.au

Referral Form

Where Did You Hear About LiveBetter?

Radio | Web / Google Search | Facebook / Twitter | Networking Event | Another Provider
LAC | LiveBetter client | NDIA referral | Other:

Referrer Details

Date of referral | Name | Organisation | Relationship

Telephone | Email | Address

Do you wish to be notified once the referral has been allocated to a therapist? Yes No

Who is to be contacted for scheduling of appointments? | Phone

Verbal Consent

Do you consent for LiveBetter to initiate services in line with the service agreement? Yes No

Initial Referral Reason

Therapeutic Services

Behaviour Support
Provisional Psychologist Yes No
New Behaviour Support Plan | Behaviour Support Plan Review

Psychology
Provisional Psychologist Yes No
Assessment | Behavioural | ASD | Adaptive | Therapy Hours
Cognitive | Diagnostic

Speech Pathology
Assessment | Communication | Swallowing | Mealtime Management Plan | Therapy Hours
Fussy Feeding | Voice | Equipment eg. iPad, AAC

Occupational Therapy
Assessment | Sensory | Functional | Fussy Feeding | Therapy Hours
Fine Motor | Equipment eg. wheelchair, toilet aid, bed
Mealtime Management Plan

Physiotherapy
Assessment | Movement / activities | Gait / falls | Hydrotherapy | Therapy Hours
Equipment eg. orthotics, walkers

Where would the participant like the service to take place at: *(** travel fees may occur as per NDIS policy)*
LiveBetter office (NIL travel fees incurred) | Own home**
Child's school / preschool** | Other**
Please list location requested for therapy:

NDIS Plan Coordination

Coordination of Supports | Support Connection | Available balance

Has the participant previously had Support Coordination with another service provider?

Community Access

Community Living Program | Available balance | Do you have a schedule of support times requested?

Individual Services / Training

Flexible Learning Program | Available balance | Support Item | Goal

Participant Details

Name | Date of birth | Age | ○ Male ○ Female ○ Other:

Telephone | Email | Address

NDIS number | Plan start date | Plan end / review date | Has a copy of current NDIS plan been provided? ○ Yes ○ No

Primary Contact Details / Person Responsible

Name | Relationship | Telephone | Email

Address | Signatory ○ Yes ○ No | Best time to contact ○ AM ○ PM | Best method of contact ○ Home phone ○ Mobile ○ Email

Personal Details

Primary Disability Group	○ ID ○ ABI ○ ASD ○ Physical ○ Neurological ○ Psychiatric ○ Deaf ○ Speech ○ Vision ○ Other:
Country of Birth	○ Australia ○ Other:
Cultural Background	○ Aboriginal ○ Torres Strait Islander ○ Other:
Primary Communication	○ Verbal ○ Non verbal ○ Other eg. Keyword, Auslan, AAC
Interpreter Required	○ No ○ Yes, language
Mobility	○ Independent ○ Wheelchair independent ○ Wheelchair with assistance ○ < 3yo ○ With aids
Hearing	○ No impairment ○ Impairment ○ Hearing device ○ Deaf
Vision	○ No impairment ○ Impairment ○ Blind
Living Arrangements	○ Own home ○ Private rental ○ Dept. Housing ○ Group home ○ Aged care ○ Supported living ○ With family ○ With others ○ Alone ○ Other:

Risk Awareness

Are there any known risk factors for staff to be aware of? eg. Restrictive practices, pets, violence.

○ No ○ Yes, if yes please give details:

Previous Service Providers

Have any previous reports or assessments been completed? ○ No ○ Yes, if yes please provide a copy to assist the therapists with.

Background Information / Reasoning For Requested Support/s