|  |  |  |  |
| --- | --- | --- | --- |
| ✓ | **NDIS Support Name and Support Item Reference Number** | **Description of Support & Support Item Reference Number** | **Support Price Per Unit\*** |
|  | Level 2: Coordination of Supports  07\_002\_0106\_8\_3 | Further qualifications/experience required to strengthen a participant’s ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. Coordination of Supports is to focus on supporting participants to direct their lives, not just their services. This may include resolving points of crisis, and developing resilience in the participant's network. | $100.14 an hour |
|  | Individual Assessment Therapy and/or Training (Includes Assistive Technology)  15\_617\_0128\_1\_3 | Assessment, recommendation, therapy, and/or training, including Assistive Technology.   * Occupational Therapy | $193.99 an hour |

Northern District Community Health

**NDIS Referral / Request for Service**





Providing NDIS Services across the Gannawarra, Loddon, Buloke Shires, Swan Hill Rural City Council, the southern end of the Wakool Shire, and western end of Campaspe Shire

**Offices in Boort – Cohuna – Kerang – Pyramid Hill – Quambatook**

For NDIS services to be provided under a participant’s NDIS plan, we need all sections filled out below. Please send this form to NDCH along with a copy of the NDIS plan and we will contact the participant directly.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service Provider to supply service/s: | | | | |  | | | | | | |
| Agency requesting the service/s: | | | | |  | | | | | | |
| Agency contact details: | | | | |  | | | | | | |
| Date of request: | Click here to enter a date. | | | | Participant Name: | |  | | | | |
| Participant Address: | | |  | | | | | | | | |
| Participant Contact Details: | | | |  | | | | | | | |
| Participant NDIS#: | |  | | | | Plan Dates: | | Click here to enter a date. to Click here to enter a date. | | | |
| Gender identity: | |  | | | | Date of Birth: | |  | | | |
| Diagnosis: | |  | | | | Hours available for this request: | | | | |  |
| Plan Manager (if not NDIA): | | | |  | | | | | Ph: |  | |
| Plan Manager Address: | | | |  | | | | | Em: |  | |
| Participant Parent/Carer: | | | |  | | | | | Ph: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **✓** | **NDIS Support Name and Support Item Reference Number** | **Description of Support & Support Item Reference Number** | **Support Price Per Unit\*** |
|  | Individual Assessment Therapy and/or Training (Includes Assistive Technology)  15\_619\_0128\_1\_3 | Assessment, recommendation, therapy, and/or training, including Assistive Technology.   * Podiatry | $193.99 an hour |
|  | Assessment, Recommendation, Therapy or Training (including Assistive Technology) - Physiotherapy  15\_055\_0128\_1\_3 | * Provision to a participant of Assessment, Recommendation, Therapy, or Training (including in assistive technology) supports. * The support must be delivered by a Physiotherapist. | $193.99 an hour |
|  | Dietitian Consultation And Diet Plan Development  12\_025\_0128\_3\_3 | Individual advice to a participant on managing diet for health and well-being due to the impact of their disability. | $193.99 an hour |
|  | Individual Assessment And Support By A Nurse  01\_618\_0114\_1\_1 | Provision of care, training and supervision of a delegated worker to respond to the complex care needs of a participant where that care is not the usual responsibility of the health system. | $151.03 an hour |

The supports listed are the most common supports requested. NDCH services under the NDIS will expand and change over time. Contact us or check our website for an up to date list of services.

**Plan Goals:**

**Additional Comments:** (e.g. Participant’s daily life, supports engaged, living arrangements)

**NDCH Contact: Ph. (03) 5451 0200 Email:** [**ndis@ndch.org.au**](mailto:ndis@ndch.org.au)

Name of person filling in this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not the Participant, role of person filling in form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I declare that this Referral / Service Request has been discussed with and agreed to by the participant.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /