**SERVICE BOOKING REQUEST**

 **Date of Booking Request:** 15 June 2021

**CLIENT INFORMATION:**

|  |  |
| --- | --- |
| **NDIS Number:** |  |
| **Participant Name:** |  |
| **Preferred Pronoun** |  |
| **Participant Address:** |  |
| **Contact Name, Phone, Email:** |  |
| **Date of Birth:** |  |
| **Vaccination Status:** |  |
| **Referrer:** |  |
| **Referrer’s relationship to participant:** |  |
| **Contact Person for intake:** |  |

 **SUPPORT COORDINATOR INFORMATION (if applicable):**

|  |  |
| --- | --- |
| **NDIS Support Coordinator:** |  |
| **Organisation:** |  |
| **Email:** |  |
| **Phone:** |  |

**SERVICE BOOKING REQUEST INFORMATION:**

|  |  |
| --- | --- |
| **Service Organisation:** | Superbia Allied Health |
| **Line Item of Service:** | Occupational Therapy ☐Physiotherapy (waitlist only) ☐PEERS Social Skills Program ☐ |
| **Diagnosis as known to NDIS:** |  |
| **Reason for referral in detail, e.g., specific OT intervention required and why:** |  |
| **Preferred location of therapy for participant, e.g., Home, Work, School etc.**  |  |
| **Availability of appointments, days and times:** |  |
| **Funds Allocated:** | (please enter total amount of funds allocated) |
| **Hours/Period/Breakdown:** | Please indicate the hours allocated for allied health services (specifying individually if using multiple services) |
| **Plan Start Date:** |  |
| **Plan End Date:** |  |
| **Funds Management:** | Plan Management / Self-Managed**Email invoices to:****Please CC emails to:** |

**\*Please email all service requests, NDIS plan and any relevant medical or allied health reports to** **alliedhealth@superbia.net.au**