Bowral clinic at 10A Boolwey St -no disability access| Tahmoor clinic Remembrance Driveway within Wollondilly Medical Centre |Please email completed form to: admin@bowralnutrition.com.au

Participant Details

First Name:	**Last Name:**
Date of Birth:	**Preferred pronouns:** ☐ She/Her ☐ He/His ☐ They/Them
Email:	**Phone:**
Address:	
NDIS-funded impairment:	
Co-occurring conditions (incl. medical, mental health, or neurodevelopmental conditions such as ADHD):	
NDIS plan number:	
Plan Start Date:	**Plan End Date:**

Participant Representative Details (If Applicable, e.g., parent)

First Name:	**Last Name:**
Relationship to client:	
Email:	**Phone:**
Address:	

Emergency contact

Emergency contact name:
Emergency contact relationship to participant:
Emergency contact phone:

NDIS Plan Management details

Plan type – please choose one: ☐ Plan-Managed ☐ Self-Managed ☐ Agency-Managed*
If Plan Managed, Plan Manager contact name:
Plan Manager email for invoices (accounts):
Plan Manager agency name (e.g., Allround Plan Management, Plan Partners, Your Plan Manager etc):

* Please note we currently provide services to agency-managed participants through our partnership with Community Links Wellbeing.

Plan details

Please include **evidence of the current NDIS goals** at the end of this referral or as a separate attachment. **This is not optional** - client goals are necessary for NDIS audits, dietetic therapy provision and review report-writing.

There is available funding in the following category:	
☐ Capacity Building - Daily Living	☐ Capacity Building - Health & Wellbeing
☐Core Supports - requires flexible core funding and may specify whether it *can* or *cannot* be used for "Disability-Related Health Supports" or "Therapy", particularly in plans issued within the past three years.	
☐ I understand that if the NDIS refuses to pay Bowral Nutrition invoices that I will be expected to pay privately	
Total funding available for dietitian: $	
Dietitian funds by funding period: ☐ Quarterly $ _____ ☐ Annual $ _____	
Funding period start/end dates:	
Plan Review Date (if known):	
☐ We will require a review report by _____ (date)	
OR	
☐ We anticipate this plan will roll over	

Referrer Details (Person Making the Referral, if different from Participant Representative e.g., Support Co-ordinator)

Name:	**Agency:**
Role: ☐ Support Co-ordinator ☐ SIL house manager/co-ordinator ☐Other – provide details:	
Email:	**Phone:**
☐ I have obtained consent from the participant to make this referral and provide Bowral Nutrition with the participant's personal and NDIS diagnosis/medical details.	

Reason For Referral

The participant or their representative has requested a nutrition assessment:
Please choose one or more: ☐ For report writing to access or justify maintaining existing funding for a dietitian ☐ To help manage their disability or co-occurring condition ☐ Participant requires enteral nutrition (tube feeding) monitoring or re-assessment ☐ Participant requires a meal plan in line with their Mealtime Management Plan from their Speech Therapist

Final checklist

I have included the participant's
☐NDIS number
☐Support Co-ordinator name and email address (if applicable)
☐Plan Manager name and email address (if applicable)
☐Funding category
☐Funding amount or hours
☐NDIS goals