Bowral clinic at 10A Boolwey St -no disability access| Tahmoor clinic 152-158 Remembrance Driveway within Tahmoor Family Medical Practice |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 (from impairment notice):	
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 Community Links Wellbeing. If the participant you are referring is NDIA-managed, please email this completed form to therapies@communitylinks.org.au .

Plan-managed and self-managed participants should email their completed forms to admin@bowralnutrition.com.au

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 - Health & Wellbeing	☐ Capacity Building - Daily Living
OR (Authority must come in writing from the NDIS Planner - not the LAC or your Support Co-ordinator)	
☐ We have authority to access Core Supports (flexible core funding)	
☐ 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 ☐ 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

☐ Participant/representative has requested a nutrition assessment.
Please choose one or more: ☐ Report writing ☐ Therapy to request NDIS funding ☐ Manage their disability
OR
☐ Participant requires enteral nutrition (tube feeding) monitoring or re-assessment