



**Bowral Nutrition**

Email: [bowralnutrition@gmail.com](mailto:bowralnutrition@gmail.com)

## NDIS referral

### Participant Details

First Name:

Last Name:

Date of Birth:

Preferred pronouns: ☐ She/Her ☐ He/His ☐ They/Them

Email:

Phone:

Street address

Town

State

Postcode

NDIS-funded impairment (from impairment notice):

Co-occurring conditions (incl. medical, mental health, or neurodevelopmental conditions such as ADHD):

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

First Name:

Last Name:

Relationship to client:

Email:

Phone:

Street address

Town

State

Postcode

### 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](mailto:therapies@communitylinks.org.au) .

Plan-managed and self-managed participants should email their completed forms to [bowralnutrition@gmail.com](mailto:bowralnutrition@gmail.com)

## Plan details

Please include a **PDF of your current NDIS plan** along with this referral or we will not be able to proceed to the next step, which is to create a Service Agreement. If your plan has rolled over, a PDF printout of the funding category totals from the portal will be additionally required (must show the date it was printed).

This is not optional - client funding evidence and client goals are necessary for NDIS audits, dietetic therapy provision and review report-writing.

NDIS number:

There is available funding in the following category

☐ Capacity Building - Health & Wellbeing

☐ Capacity Building- Daily Living

**OR**

☐ we have authority to access Core Supports (flexible core funding)

☐ we have authority to access Early Childhood Core Supports (flexible core funding)

**Total funds available for dietitian: \$**

Plan Start Date:

Plan End Date:

Plan Review Date (if known):

☐ We will require a review report by (insert date)

**OR**

☐ We anticipate this plan will roll over when it expires

## Referrer Details (Person Making the Referral)

First name:

Last name:

Agency:

Role:

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 (please choose one) has requested assistance with (please list concern/s below)

☐ Participant requires enteral nutrition (tube feeding) monitoring or re-assessment