**DATE:** Click or tap here to enter text.

**PROVIDER:** Access Health & Community, 283 Church Street, Richmond, VIC, 3121, Australia. Ph. 9810 3000

**WHO TO CONTACT:**

Participant  
 Alternate Contact

|  |  |  |  |
| --- | --- | --- | --- |
| **Participant Details** | | | |
| Name: | Click or tap here to enter text. | Address: | Click or tap here to enter text. |
| DOB: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. | NDIS No: | Click or tap here to enter text. |
| Plan Start Date: | Click or tap here to enter text. | Plan End Date: | Click or tap here to enter text. |
| Preferred language | Click or tap here to enter text. | GP details | Click or tap here to enter text. |
| Current Accommodation | Click or tap here to enter text. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Alternate Contact** | | | |
| Name: | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
|  |  |  |  |

|  |
| --- |
| I wish to refer the above NDIS participant to your organisation for |
|  |

|  |
| --- |
| This participant has a diagnosis of |
|  |

|  |  |
| --- | --- |
| **Service Request Details** | |
| Service: | Click or tap here to enter text. |
| Preferred Day: | Click or tap here to enter text. |
| Time: | Click or tap here to enter text. |
| Other/Preference: | Click or tap here to enter text. |
| Access HC to provide a copy of the **Service Agreement** and Statement of Service/**Schedule of Supports** to participant and Support Coordinator, where appropriate. | |

|  |
| --- |
| **PLAN EXTRACT** |
| Please include Participant’s NDIS number, plan dates and relevant support category/budget area |
|  |
|  |
| **GOALS** |
| Please include participants NDIS goals |

**PAYMENT:**

Participant has chosen the following payment method. For billing issues, please contact NDIA.

(Please tick chosen method):

**The National Disability Insurance Agency**

**Plan Management Provider**

Office Address: Click or tap here to enter text.

ABN: Click or tap here to enter text.

Email: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

**Participant is self-managing funding.**

Email: Click or tap here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
| Name: |  | Relationship: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |