



AuriHealth Referrer Enquiry Form

Name	
Organisation	
Relationship to client	
Your phone number	
Your email address	

CLIENT INFORMATION

Client name	
Client phone number	
Client email address	
Client address	
Primary disability	

WHO ARE WE CONTACTING ABOUT THIS ENQUIRY?

Referrer

Client

Other

If other, name and relationship to client	
Contact's phone number	
Contact's email address	

Does this person have a current NDIS Plan?

Yes

No

If yes, what is their NDIS Number?	
Do you know their current Plan dates?	Start: End:

SERVICES REQUIRED

Support Coordination

Do they have Support Coordination funding in their Plan?	Yes	No
Have they previously had a Support Coordinator? If yes, who?		
Any other important information?		

Plan Management

Do they have Plan Management funding in their Plan?	Yes	No
Have they previously had a Plan Manager? If yes, who?		
Any other important information?		

NDIS Access

Is there a current application in process?	Yes	No
Is there supporting documentation from Allied Health, GP or other?	Yes	No
Any other important information?		

Unsure at present

Any other important information?	
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Please send this completed form to katana.smith@aurihealth.com.au