Pleasant Sense Farm

Sustainability. Therapy. Connect.

Referral Form

Please complete this form to request any of the following therapy services or programs:

- Occupational Therapy
- Animal Assisted Therapy
- Nature Connect Program
- Farm Animal Program

Please provide as much detail as possible. Fields marked with a red asterisk are required.

Service/s Requested

Please select one or more services you'd like to request for the participant

□ Occupational Therapy
□ Animal Assisted Therapy
□ Nature Connect Program
□ Farm Animal Program

Participant Details

The participant is the person who will be participating in the sessions

First Name*: Last Name*:

Date of Birth*:

Gender *:

□ Female
□ Male
□ Prefer not to say

Address*:

State*:

Post Code*:

Participant Phone: Participant Email:

Country of Birth:

Primary Language:

Do you require a language Interpreter? (Yes/No)

Aboriginal or Torres Strait Islander? (Yes/No/Prefer not to say):

Any allergies or dietary requirements?

□ Yes
□ No

If Yes, Please list any allergies or dietary requirements here*:

Diagnosis/Disability (If applicable) *:

Funding*:

□ Self funded/private
□ NDIS funded (self managed or plan managed)

Participant NDIS Number*:

How is the Plan Managed?
(If NDIS funded) *
□ Self-Managed
□ Plan Managed
□ Agency Managed

Additional needs, behavioural issues, challenges (e.g. anxiety, ADHD, phobias, coping mechanisms, event triggers etc.)

Name of school (if attends):

Preferred First Contact*: (Participant/Primary Carer/Plan Nominee/Other)

□ Participant
□ Primary Carer
□ Plan Nominee
□ Other

Primary Carer Details

Primary Carer is the parent or guardian with primary care responsibilities for the participant

First Name*: Last Name*:

Relationship to the participant*:
E.g. parent, guardian, support worker, carer, etc

Phone (mobile preferred) *:

Email Contact*:

If Plan-Managed please provide details:

Plan Manager Organisation Name:

Contact Person Name (if known):

Plan Manager Phone:

Plan Manager Email:

This email is where invoices will be sent for payment.

Support Coordinator Details

Does the participant have a Support Coordinator*?

□ Yes
□ No

If Yes,

Support Coordinator Name:

Support Coordinator Phone Number:

Support Coordinator Email address:

Referrer Details

First Name*: Last Name*:

Referrer relationship to the participant*:

Referrer Phone*:

Referrer Email*:

Reason for Referral

If applicable, please attach a copy of the Participant's NDIS Plan

Once submitted, we will contact you to discuss the participant's needs.
If you have any questions or difficulties completing this online form, please call us on 0448 557 329.
