

GROW WELLBEING

NDIS and MEDICARE Provider

for better mental health

Check out our official website www.growwellbeing.com

Helping children to be the best they can be

admin@growwellbeing.com 08 8234 2562 121 North East Rd Collinswood SA 5081





With a multidisciplinary team of experts offering:

- Psychology

- Occupational Therapy

- Speech Pathology

- Psychotherapy

- Therapy Assistant

- Social Skills Groups

- Sensory Integration Therapy

Grow Wellbeing can assist you and your child in the following areas and much more:

- Behavioural/Mental Health Conditions

- Learning Difficulties - ADHD

- Emotional regulation

- Developmental Conditions

- School attendance

- Sleeping difficulties

- Family Support

- ASD

- Friendship skills

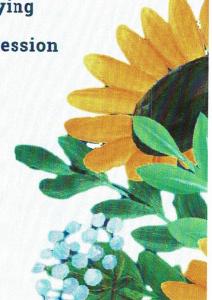
- Anxiety

- Bullying

- Depression



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1. NDIS PARTICIPANT DETAILS

Grow Wellbeing Pty Ltd 121 North East Road Collinswood SA 5081 ABN: 21 626 180 096 Ph: (08) 8234 2562 Fax: (08) 8219 0049

admin@growwellbeing.com

GROW WELLBEING REFERRAL FORM FOR NDIS PARTICIPANTS

First Name:	The state of the s		
	Last Name:		
Date of Birth:	Phone:	Phone:	
Gender:	Email:		
Address:			
Contact Person: (only if different to	above)		
Name:	Phone:		
Relationship:	Email:	Email:	
Support Coordinator details (if ap	olicable)		
Name:	Phone:		
Email:			
NDIS Plan Number:	NDIS Plan End Da	NDIS Plan End Dates:	
Tables address a second	Start Date	to End Date	
School Name: (if applicable)			
☐ Psychological Support	☐ Behavioural Suppo	ort	
☐ Group Therapy			
		Mentoring	
Services	ccupational Therapy Services		
. THERAPY			
Yes No	peutic Support within the last 6 months		
f Yes please describe or attach re	evant reports when submitting this form	1. (Optional)	
Does the participant have a behav	oural support plan in place?	□Y□N	
s the participant interested in Homapplicable)	e visits during School Holidays or after	school? (if YNN	



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4. SERVICES AND PAYMENTS Grow Wellbeing services fall within the NDIS Improved Daily Living budget

What typ	pe of report is required? Short Detailed
Grow Wo	ellbeing charges the standard NDIS rate of \$193.99(OT, Psychotherapist, Speech gist)/\$234.83 (Psychologist) per hour for Area MMM1-5
How ma	ny hours of service are you requesting?
h	ours service @ \$193.99 / \$234.83 per hour (from Improved Daily Living budget)
OR	
☐ To be	e discussed with Grow Wellbeing
5. PAYI	MENT OF ACCOUNT / INVOICES
Who is re	esponsible for paying the account / invoice? (please select one)
☐ NDIA	Managed
☐ Plan I	Managed
Self-N	Managed
If you se	elected Plan Managed or Self Managed, please complete the following details:
	person or Plan Manager responsible for the account:
Phone:	3
	or invoices):
	0.000).
7. TO C	OMPLETE THIS REFERRAL FORM
	In order to process your referral efficiently, we will need a copy of your NDIS Plan or appropriate details as listed below:
- NI	DIS Plan Number
	an dates
– NI	DIS Goals
	This information is important to assist the services we will provide to you.
	Print name:
	Sign: Date:
	Please sign and date this referral. Our NDIS Coordinator will make contact with you regarding accessing our services. Please return via email the completed form to: ndis@growwellbeing.com

Thank you for filling in this referral form, we look forward to working with you!