

# NDIS Service Provider Request Form



**Date:**

**Provider:** 4050007361

**Organisation:** Geelong Rehabilitation Centre

**Contact:** James Tantau

**Email:** geelongrehabilitationcentre@gmail.com

PARTICIPANT HAS APPROVED CONSENT TO ENGAGE WITH PROVIDER

Please State

Participant's Name		DOB:	
Address			
Preferred Contact #		Disclose Phone calls from SSC	
Email		Preferred Contact Time	
Disability Type		NDIS #	
Plan Start Date		Plan End Date	
ALTERNATE CONTACT / NEXT OF KIN			
Name		Relationship	
Phone #		Email	
SERVICE REQUEST DETAILS			
Service Required			
Start Date		End Date	
Frequency		Duration	
Relevant Line Items	<b>(15_062_0128_3_3) NDIS Dietetics Initial DL (EXAMPLE ONLY)</b>		
Fund Management Type			
Further Details			

Health Conditions	
Alerts- Pets, Risks, Smoking etc	
Behaviours of Concern	

PLAN MANAGER DETAILS (where applicable)	
Nominated Plan Manager	
Provider Email	
Approval of Invoice payment will be completed by:	

SUPPORT COORDINATOR DETAILS			
Name		Mobile	
Email			

ADDITIONAL INFORMATION