NDIS Occupational Therapy Services - Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/services/occupational-therapy-alt/

Details:

This page is for the people who make the referral rather than the person receiving the service. It covers what to put in a referral, what happens between the referral landing and the first session, how the three plan management types change the paperwork, what communication and reporting you get back, and the protections that apply to every NDIS participant. To refer, call 1300 771 465 or use the referral form .

If you want the participant-facing explanation of what occupational therapy is and who it is funded for, that is on Occupational Therapy .

What to include in a referral

A referral can be actioned faster and allocated to the right clinician when it includes:

participant details and NDIS number

plan dates , and how the plan is managed: self-managed, plan-managed or NDIA-managed

current goals , written exactly as they appear in the plan

the daily life problem you want solved , not just the service name

relevant diagnoses and functional impact

risks : falls, choking, behaviours of concern, carer strain, manual handling

what supports are already in place and what is not working

preferred setting : home, school, workplace, community, clinic

consent and contact details , including who is the right person to book with

If the referral is for a specific assessment, name it and say what it is for. "Functional capacity assessment for a plan reassessment due in March", "assistive technology review, current chair no longer fits", "complex home modification, bathroom". That determines who is allocated and how much time is set aside.

What happens after a referral lands

1. Allocation. The referral is allocated to a clinician suited to the presenting needs.
2. Confirming who decides. We confirm the funding arrangement and who the decision maker is. For self-managed participants that is the participant or their nominee. Where a support coordinator or care coordinator is involved, we contact them first and then confirm who to book the appointment with.
3. The conversation before booking. Before anything is booked we discuss the purpose of the referral, the cost of the services, an estimate of hours or a quote, and the best email address for invoices. Telling participants the price of NDIS supports before delivering them is a provider obligation, not a courtesy.
4. Intake form. Completed as part of this process.

5. Service agreement and consent. A service agreement is a written agreement between the provider and the participant covering the supports to be delivered and the conditions attached. It should be executed before the first appointment. It covers participant and funding details, service scope and cost, emergency contact details, and consent to the collection, use and disclosure of personal information under the Privacy Act 1988. Where the participant does not have capacity to sign, appropriate alternative arrangements are made with the substitute decision maker. Anything in it can be explained before it is signed, and changes to an existing agreement have to be discussed and agreed before they are made.
6. Booking and first session. The first session gathers what the clinician needs to build an action plan. A safety check is done at the first meeting and any risks are discussed, then reviewed on an ongoing basis under work health and safety obligations. Participants and families are asked to tell staff about unsafe conditions in the home.
7. Multidisciplinary coordination. After assessment the clinician connects with other disciplines already on file and schedules a care team meeting to gather updates, agree collaborative goals, discuss barriers and plan forward. Coordination and internal therapy planning are billable activities, because progress usually depends on the team working together rather than in parallel.

What each plan management type means in practice

Self-managed

The participant controls the funding directly. They can use any suitable provider that meets NDIS rules, which gives the most flexibility. They pay the provider and claim reimbursement from the NDIS. Invoices go to the participant or their nominee, and they keep the records.

Plan-managed

A registered plan manager handles the financial administration. The participant can use registered or unregistered providers. Providers invoice the plan manager, who pays on the participant's behalf and gives summary statements. Plan managers also track spend against budget, which is how overspending gets caught before it becomes a problem.

NDIA-managed

The NDIA pays providers directly through the portal. The participant must use NDIS registered providers only . They do not receive invoices. Providers claim through the portal, and payment requests must be submitted within 90 days of service delivery.

Whichever applies, provider charges must sit within the NDIS Pricing Arrangements and Price Limits. Invoices are issued after a support has been delivered, and payment cannot be requested before delivery. Fees, travel and cancellation terms are set out in the service agreement before services start. For current pricing in a particular situation, call 1300 771 465 .

What you get back: communication and reporting

This is usually the part that decides whether a referral was worth making.

Case notes. Documentation is entered within 24 hours of service delivery, covering location, who attended, what was discussed, observations, goals and follow-up. All client contact is documented on file, including phone calls, emails and unanswered calls, so the file reflects the current state rather than the last formal session.

Service updates. Where relevant, updates after an occasion of service identify goals, strategies, progress and next actions.

Formal reports. Before a report is written, the clinician confirms with the participant or nominee, and the funding body where relevant, whether a report is required, what its purpose is and what type is needed, so it is fit for purpose. Reports are sent to relevant stakeholders by email in PDF.

Plan reassessment reports. These are clinical documents covering current presentation, functional impact, progress, risks and recommendations written in NDIS terms.

Incidents. Critical incidents are reported to management under a two-step process: the staff member completes an electronic incident report and the manager completes a corrective action plan. Full, timely and accurate notes are kept about suspected, observed or alleged harm, risk of harm, abuse or neglect.

Exit. Where a participant leaves the service, exit is planned rather than abrupt, and a final written report is offered covering the services and supports received, the staff and disciplines involved, and where possible the goals and outcomes achieved. Where someone is moving to another service, our staff can meet with the new provider and the family to hand over information and reports. Participants may request a copy of their file at or after exit.

If an appointment cannot go ahead, let us know as early as possible. Notice expectations and any cancellation terms are set out in the service agreement.

For carers and families

If you are the person who does the lifting, the reminding and the appointments, you are not a bystander in this service. You are part of how it works.

You inform the assessment. Families and carers see the daily reality and provide insight into challenges and support needs that a clinic room does not show. That evidence goes into the functional capacity assessment.

You are coached, not just informed. Family and carer training gives practical guidance so the people around the participant can use consistent strategies in everyday situations. It is delivered through coaching and collaboration using adult education principles, role modelling where the clinician demonstrates a strategy for you to observe and then apply, and carer coaching on managing behaviour, emotions, communication and daily support. Additional capacity building sessions can be offered at times that suit families, such as school holidays.

Carer strain is a target, not a side note. Carer strain is the physical, emotional and social load of supporting someone, and it accumulates. Occupational therapy works on it by increasing the participant's independence in daily tasks, reducing manual handling strain during transfers and personal care, and recommending equipment and home changes that make the physical work of caring smaller. If carer strain is the reason for the referral, say so in the referral. It changes what gets prioritised.

Who does what

Support coordinator. Connects participants with providers across disciplines, organises referrals, helps people understand and use their plan, and keeps services aligned across providers. Focused on coordination and planning, not on delivering therapy. There are tiered levels of support coordination reflecting different levels of complexity.

Plan manager. Financial administration. Manages funding for plan-managed participants, processes provider payments, issues summary statements, and can make referrals on the participant's behalf.

Local area coordinator. Connects people to supports, helps them take part in assessment, and works with them in planning meetings to build the plan. LACs work with children aged nine and over, teenagers and adults, while early childhood partners work with younger children.

Key worker. For children, one clinician coordinates across the team so the family has a single point of contact rather than five separate therapy relationships.

The protections that apply

The NDIS Code of Conduct applies to all registered and unregistered providers, their key personnel and their workers. It requires them to act with respect for individual rights to freedom of expression, self-determination and decision making; respect privacy; deliver supports safely and competently with care and skill; act with integrity, honesty and transparency; promptly raise and act on concerns about quality and safety; take all reasonable steps to prevent and respond to violence, exploitation, neglect and abuse; take all reasonable steps to prevent and respond to sexual misconduct; and not charge or represent higher prices for goods supplied to NDIS participants without reasonable justification.

Registered providers must also comply with the NDIS Practice Standards , which have a Core Module covering participant rights and responsibilities, provider governance and operational management, provision of supports, and support environments, plus supplementary modules for specific service types including specialist behaviour support, early childhood supports, specialised support coordination, specialist disability accommodation and supported independent living. Registered providers are audited against these standards. The NDIS Commission's Worker Orientation Module, "Quality, Safety and You", is mandatory for all staff of registered providers.

Worker screening. NDIS Worker Screening Checks are required for employees, volunteers, contractors and students working for registered providers in risk-assessed roles, meaning roles involving more than incidental contact with participants, and for key personnel. Checks are valid for up to 5 years, with renewals able to be lodged up to 90 days before expiry. Registered providers must keep written records about risk-assessed roles and the workers in them, including screening check numbers and expiry dates, for 7 years after a worker is unlinked.

Complaints. Registered providers must have a documented complaints management and resolution system, including the ability to complain anonymously, accessible platforms and languages, involvement of the complainant in the resolution, referral pathways including to law enforcement where a criminal offence may have occurred, record keeping and staff training. Raise a concern with the provider first if you feel able to. If it is not resolved or you do not feel safe doing that, anyone concerned about the quality or safety of NDIS supports, including family, carers and workers, can report it directly to the NDIS Commission. Threatening someone or obstructing them from making a complaint is against the law.

When occupational therapy is not the right referral

Send it anyway and say what the problem is, and we will tell you if another discipline should lead. Common redirections:

acute pain, post-surgical rehabilitation or a new musculoskeletal problem, which is physiotherapy

communication, speech, language or swallowing, which is speech pathology

behaviours of concern needing a behaviour support plan, which is positive behaviour support

formal psychometric cognitive assessment and psychological therapy, which is psychology and counselling

long term physical capacity and chronic condition management through prescribed exercise, which is exercise physiology

nutrition and mealtime management, which is our dietitian service

Often more than one is needed, in which case the sequencing matters more than the list.

How to refer

Call 1300 771 465 , use the referral form , or contact us . Referrals are accepted from participants themselves, parents and carers, support coordinators, plan managers, GPs and paediatricians, schools, SIL providers and community teams. A GP referral is not required for NDIS occupational therapy.

Services are delivered across New South Wales , South East Queensland , Victoria , Western Australia , South Australia , Tasmania and the Australian Capital Territory. See all locations .

A plain English guide for participants is available: Easy Read guide to occupational therapy and the NDIS .

Common questions about referring to occupational therapy

What is the minimum I need to send to make a referral?

Participant details, NDIS number, how the plan is managed, the problem you want solved, and consent and contact details. Everything else speeds up allocation but will not stop a referral being accepted.

Can I refer if the participant is NDIA-managed?

Yes, provided the provider is NDIS registered, because NDIA-managed participants must use registered providers. Plan-managed and self-managed participants can use registered or unregistered providers.

When does billing start?

After delivery. Invoices are issued after a support has been delivered and payment cannot be requested in advance. For NDIA-managed participants, payment requests must go in within 90 days of service delivery. The service agreement should be signed before the first appointment.

Will I be told the cost before we start?

Yes. Telling participants the price of supports before delivering them is a provider obligation, and an estimate of hours or a quote is part of the intake conversation.

How do I get a report for a plan reassessment?

Ask for it at referral, and say when the reassessment is due. Reports for reassessment cover current presentation, functional impact, progress, risks and recommendations in NDIS terms, and are emailed as PDFs. The purpose and type of report is confirmed with the participant or nominee before it is written, so it is worth being explicit about what the plan reassessment actually needs.

How quickly are case notes available?

Documentation is entered within 24 hours of service delivery, and all contact including calls and emails is recorded on file.

What happens if there is an incident?

Critical incidents are reported to management under a two-step process, with an electronic incident report from the staff member and a corrective action plan from the manager. Notes about suspected, observed or alleged harm, risk of harm, abuse or neglect are kept in full.

Who do I complain to if something goes wrong?

Raise it with the provider first if you can. Registered providers must have a complaints system that allows anonymous complaints and involves you in the resolution. If it is not resolved or you do not feel safe raising it, report it to the NDIS Commission. Anyone can, including family, carers and workers.

Do all the workers have screening checks?

NDIS Worker Screening Checks are required for workers of registered providers in risk-assessed roles, meaning more than incidental contact with participants, and for key personnel. Checks last up to 5 years and providers must keep records of screening numbers and expiry dates.

Can therapy include training for the family or support workers?

Yes. Family and carer training is part of the capacity building approach, delivered through coaching, role modelling and collaboration so the strategies are used consistently between sessions. Sessions can be scheduled at times that suit families.

What happens when the participant finishes with the service?

Exit is planned. A final written report is offered covering the supports received, the staff and disciplines involved and the goals and outcomes achieved. Where someone is moving to another provider, our staff can meet with the new service and the family to hand over. A copy of the file can be requested.

Can several disciplines be referred at once?

Yes, and it is common. After assessment the clinician connects with the other disciplines on file and schedules a care team meeting to agree collaborative goals and work through barriers. Say at referral who else is involved so it is coordinated from the start rather than retrofitted.

What is the focus of Bloom Healthcare's Occupational Therapy service?

Bloom Healthcare's Occupational Therapy service uses activities to assess and treat disabilities that affect a person's ability to perform daily tasks, helping individuals achieve greater independence and improve quality of life through meaningful engagement in daily activities.

What is occupational therapy?

Occupational Therapy is a person-centered allied health discipline that focuses on helping individuals overcome physical, cognitive, and emotional barriers to independence, enabling them to engage in meaningful activities (called 'occupations') that enhance their well-being and quality of life.

In what settings do occupational therapists work?

Occupational therapists work across various settings including homes, schools, community environments, and clinical settings to support individuals in implementing strategies into their daily routines and environments.

What three dimensions of well-being does occupational therapy support?

Occupational Therapy services support physical well-being (through improved mobility, strength, and functional capacity), cognitive well-being (including memory, attention, and executive functioning), and emotional well-being (through emotional regulation and mental health support).

Who can benefit from occupational therapy services?

Occupational Therapy benefits diverse populations, including individuals with disabilities, children with developmental delays, adolescents aged 10-17 needing support with growth, function, and identity development, older adults and seniors maintaining independence, people recovering from illness or injury, and individuals with specific conditions such as ADHD, autism spectrum disorder, and dementia.

Does occupational therapy include assessment services?

Yes, occupational therapy services include assessment and planning, such as Functional Capacity Assessments (FCA), used to evaluate a person's abilities and support needs.

Is Bloom Healthcare's Occupational Therapy relevant to NDIS participants?

Yes, the page is titled 'NDIS Occupational Therapy Services' and describes Bloom Healthcare's Occupational Therapy as using activities to assess and treat disabilities that affect daily tasks, positioning it as an NDIS-related occupational therapy service.

What is Bloom Healthcare's contact phone number?

Bloom Healthcare's telephone number is 1300 771 465.

What kind of organization is Bloom Healthcare?

Bloom Healthcare is a boutique disability and aged care allied health provider that believes all people have the right to access quality healthcare, with a healthcare model focused on evidence-based practice and client centricity, delivered by highly qualified health practitioners across Australia.

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