



NEURODIVERGENT EMPOWERED

NDIS Registered Provider | Registration: 4-K6GFD9R

Allied Health Delegation & Collaboration Form

(To be completed by the Treating Allied Health Professional)

This form documents the requirements for delegated program delivery by Therapy Assistants at Neurodivergent Empowered, in accordance with NDIS Therapy Supports guidelines.

Delegated delivery does not commence until this form and all required attachments are received and approved.

1. PARTICIPANT DETAILS

Participant Full Name:

NDIS Number:

Date of Birth:

NDIS Plan Dates:

2. TREATING ALLIED HEALTH PROFESSIONAL DETAILS

Profession (tick one):

Occupational Therapist	Speech Pathologist	Physiotherapist
Psychologist	Exercise Physiologist	Dietitian
Social Worker	Music Therapist	Art Therapist
Podiatrist	Other:	

AHP Full Name:

Practice / Organisation:

Registration Body: AHPRA SPA ESSA AASW Other:

Registration Number:

Email: Phone:

I confirm that I am the treating Allied Health Professional for the participant named above.

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Yes – I confirm

4. THERAPY PROGRAM OVERVIEW

(Attach intervention plan/program to this form)

I confirm that I have:

- completed an assessment for this participant within my professional scope
- developed an intervention plan/program
- identified components appropriate for delegation for implementation

Therapy Goals (discipline-specific) – briefly list or reference attached plan:

5. DELEGATED INTERVENTION COMPONENTS

Components APPROVED for delegation for implementation by Therapy Assistants:

(Tick all that apply or specify in "Additional components")

- Routines/sequences specified by AHP (timing, duration, conditions defined)
- Skill practice embedded in motivating activities
- Environmental adaptations as specified
- Graded tolerance or exposure routines within defined parameters
- Collection of observational data specified below

Additional delegated components (describe with parameters):

Components NOT approved for delegation (confirmed):

- Assessment or reassessment
- Clinical judgement or interpretation
- Program modification
- Introduction of new strategies
- Diagnosis or discharge decisions

6. THERAPY ASSISTANT TRAINING & COMPETENCE

Neurodivergent Empowered advises that the assigned Therapy Assistant has completed the following training program (verified by Neurodivergent Empowered, full Training Register available on request):

NDIS Compliance Prerequisites:

- NDIS Worker Orientation Certificate
- Support People to Stay Infection Free Certificate
- NDIS Code of Conduct (Safety, Integrity, Eliminating abuse, Fair pricing)

Neurodivergent-Affirming Practice:

- Professional Certificate of Neurodivergent Affirming Practices
- Brains = Behaviours (neuroscience-based, trauma-informed)

6. THERAPY ASSISTANT TRAINING & COMPETENCE (continued)

PDA & Demand Avoidance Specialisation:

- Understanding PDA: Pathological Demand Avoidance
- PDA: It's Not What You Think (Dr. Neff)
- Communicating safety to the demand avoidant, anxious brain
- Fight, Flight, Freeze & Fawn: Threat response in demand avoidant children

Regulation & Sensory Processing:

- Chaos to Calm: Big Feelings & Bigger Behaviours (Foundation + Modules)
- Sensory Smart: Applying Sensory Processing in Play Therapy
- Autism & Anxiety: Helping Children to Thrive

Play Therapy & Digital Engagement:

- Minecraft as Digital Sand Tray in Play Therapy
- Roblox in Play Therapy
- LEGO-Based Play Therapy
- Video Games & Thematic Play in the Digital World

LGBTQIA+ Affirming Practice:

- LGBTQ+ Introduction
- Trans-Affirming Workplaces & Practice
- Neuroqueer Identities (Dr. Neff)

Trauma-Informed Practice:

- Managing Stress & Meltdowns
- Understanding Anxiety: A Strength-Based Approach
- Autism, Masking & Pathologising

I acknowledge that Neurodivergent Empowered has advised me of the above training completion and I accept this as meeting Level 2 Therapy Assistant competence requirements for delegation.

Acknowledged – I accept responsibility for the decision to delegate

7. FEEDBACK REQUIREMENTS

All feedback is provided asynchronously (written). Select the feedback you require:

- All session notes (provided after each session)
- Quarterly summary reports
- Annual summary reports

Specific observations required (tick all that apply):

- | | |
|-----------------------|----------------------------|
| Engagement duration | Tolerance indicators |
| Recovery time | Task initiation/completion |
| Environmental factors | |
| Other (specify): | |

8. SUPERVISION ARRANGEMENTS

All supervision is asynchronous (written case review). Neurodivergent Empowered provides:

- Allied health professional development for Therapy Assistants
- Case review supervision by an Occupational Therapist (asynchronous)
- On-site ACA Level 2 Counsellor oversight for immediate escalation

I confirm that:

- I will review feedback within a reasonable timeframe
- I will lead all clinical adjustments to the program (communicated in writing)
- Clinical responsibility for the allied health program remains with me

9. CONSENT CONFIRMATION

I confirm that:

- participant consent is in place for two-way information sharing
- shared information will be used solely for coordinated care

10. WORKFORCE & ETHICAL COLLABORATION

I acknowledge that:

- Neurodivergent Empowered invests significantly in workforce training and governance
- Therapy Assistants operate within a defined governance structure
- Active solicitation or recruitment of Neurodivergent Empowered staff during collaboration and for 12 months following is not appropriate

11. DECLARATION & SIGNATURE

I declare that:

- the information provided is accurate
- delegation is intentional, specific, and within scope
- I retain clinical responsibility for the allied health program

AHP Name (print):

Signature:



Date:

Electronic signatures are valid and enforceable under the Electronic Transactions Act 1999 (Cth) and Electronic Transactions (Queensland) Act 2001. Typed name or digital signature accepted.

12. REQUIRED ATTACHMENTS CHECKLIST

(Must be attached before delegated delivery begins)

- Intervention plan / program
- Delegation & Collaboration Form (this document)
- Consent confirmation (or confirmation held by AHP)

Submit completed form and attachments to:

sparkly@neurodivergentempowered.com.au

FOR NEURODIVERGENT EMPOWERED USE ONLY

Form received by:

Date received:

AHP Profession:

Registration verified: Yes No – follow up required

Attachments verified: Yes No – follow up required

Assigned Therapy Assistant:

TA training verified: Yes

Delegation start date:

Notes:

IMPORTANT INFORMATION

This form is the anchor document for AHP delegation at Neurodivergent Empowered.

Without this completed form, delegation is implied. With this form, delegation is explicit and defensible.

This form:

- Proves AHP intent and authorisation
- Proves TA training was advised and acknowledged
- Proves delegation scope boundaries
- Proves oversight structure

For queries: sparkly@neurodivergentempowered.com.au