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| Occupational Therapy Services Referral Form |  |

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The following services are requested (please tick):

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| --- | --- |
| [ ]  Activities of Daily Living Assessment & Retraining | [ ]  Workplace Assessment |
| [ ]  Home Assessment | [ ]  Office Ergonomic Assessment |
| [ ]  Minor Home Modifications | [ ]  Equipment Prescription |
| [ ]  Support Needs Assessment | [ ]  Manual Handling Training |
| [ ]  Equipment Assessment & Prescription | [ ]  Functional Assessment |
| [ ]  Cognitive Rehabilitation | [ ]  Task Analysis |
| [ ]  Wheelchair Prescription [ ]  manual [ ]  power | [ ]  Other:       |
| [ ]  Brainwave R Cognitive Rehab Program |  |

Referral Details

|  |  |  |  |
| --- | --- | --- | --- |
| Client’s Name: |       | Date of Birth: |       |
| Address: |       |
| Telephone: |       | Date of Injury: |       |
| Email Address: |       | Claim No: |       |

|  |  |
| --- | --- |
| Current Appointments: | Enduring Guardian [ ]  Power of Attorney [ ]  Administrator [ ]  |

|  |  |
| --- | --- |
| Primary Contact Person/NOK: |       |
| Relationship: |       |
| Are they aware of this referral? | Yes [ ]  No [ ]  |

|  |  |
| --- | --- |
| Primary & secondary diagnosis: |       |

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| --- | --- | --- | --- |
| Employer Name: |       | Contact Name: |       |
| Address: |       |
| Telephone: |       | Email: |       |

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| Reason for Referral: |       |

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| --- | --- |
| Living/Social Situation |       |

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| Known risks for Home visiting purposes (pets, smoking, domestic violence, family disputes, alcohol/ substance use etc.) |
|       |

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| --- | --- |
| Other Relevant Information: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurer: |       | Claim No: |       |
| Insurer Contact: |       |
| Email / Phone: |       |

|  |  |
| --- | --- |
| General Practitioner: |       |
| Address: |       |
| Email / Phone: |       |

|  |  |
| --- | --- |
| NDIS Participant Number |       |
| NDIS Plan | Start Date: |       | End Date: |       |
| Funding Management | Agency Managed [ ]  Plan Managed [ ]  Self-Managed [ ]  |
| Allocation for OT hours |       |
| Email contact for funding purposes: |       |
| Plan Goals: | 1.
2.
3.
4.
 |

|  |  |
| --- | --- |
| Contact to send Invoices: |       |
| Email Address: |       |

|  |  |
| --- | --- |
| Contact to send report: |       |
| Name: |       |
| Role: |       | Email Address: |       |

Referrer Details

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       |  |  |
| Phone: |       | Email: |       |
| Agency: |       | Role: |       |
| Signature: |       | Date: |       |

Please forward this referral form to OT Rehab Services via email to contact@otrehabservices.com.au