REFERRAL FOR OCCUPATIONAL THERAPY SERVICES

DATE REFERRAL: **REFERRAL TYPE**: ☐ NDIS ☐ Aged Care

☐ Private Health ☐ Insurer DVA: ☐ Gold ☐ White ☐ Medicare ☐ Other

1. CONSUMER / PARTICIPANT DETAILS

First Name:	Last Name:
Date of Birth:	Phone:
Gender: ☐ Male ☐ Female ☐ Non binary	Email:
Address: Suburb: State: Postcode:	
Alternative Contact/ Nominee / Guardian : Name: Phone: Relationship:	
NDIS Plan Number: Plan Dates: to	Doctor: Phone:
Living Arrangement: ☐ Alone, ☐ Family/Partner, ☐ Supported Accommodation, ☐ Other	
Preferred Language: Translator/interpreter or communication aids required? Yes ☐ Details:	

2. REFERRER ☐ Check this box if referring yourself – go to **Section 3**

Organisation:	
First Name	Last Name:
Phone:	Email:
Role: ☐ Support Coordinator ☐ Case Manager ☐ Health/ Medical Professional ☐ Local Area Coordinator ☐ Family member ☐ Other:	

3. HEALTH CONDITION / DISABILITY

Please provide a brief summary of the health condition / primary disability to enable the most suitable therapist to be allocated (eg: Intellectual Disability, Cerebral Palsy, Stroke, Multiple Sclerosis, Dementia etc)

Please return Referral Form via email info@alliedlifepartners.com.au - We look forward to supporting you

4. SERVICE NEEDS

☐ Functional Assessment	☐ Cognitive Assessment
☐ OT Home Modifications ☐ Housing Assessment - ☐ SIL ☐ SDA ☐ ILO	
☐ Assistive Technology (equipment)	☐ Adult Therapy Services
☐ Aged Care Wellness & Reablement	☐ Vocational Assessment & Services
☐ Planning or Plan Review Assessment	☐ Disability & Quality Consulting
☐ High/ imminent risks? ☐ Falls Risk ☐ Pressure injuries ☐ Sudden decline in function	
☐ I would like my services to be delivered via ***telehealth*** (video or phone)	
Brief summary of goals and barriers? ☐ Medical/ health reports ☐ NDIS Plan attached	

5. RISK SCREEN ☐ Are there any known risks / Risk assessment (attach)

*(in order to proceed with your referral ALL questions **MUST** be ticked)*

Is anyone at the home known to be aggressive, violent or have a criminal history ?	☐ Y ☐ N
Behavioural concerns, behaviour support plans or mental health concerns? Describe	☐ Y ☐ N
Is there a history of people using drugs or alcohol at the property?	☐ Y ☐ N
Are you aware of any firearms being stored at the property?	☐ Y ☐ N
Are you aware of anyone having an infectious disease? (includes Covid19)	☐ Y ☐ N
Are there any pets at your premises? Are the pets unable to be restrained?	☐ Y ☐ N
Are there any other issues to be aware of?	☐ Y ☐ N

6. SERVICES AND PAYMENTS

Anticipated Occupational Therapy hours requested (if known) _____ Hours

Please nominate who is responsible for paying the account / invoice

☐ NDIA *(selecting this option authorises us to create a Service Booking for the hours nominated)*

☐ NDIS Self-Managed:

☐ NDIS Plan Manager:

☐ Aged Care Provider:

☐ Insurer/ Other:

Name of person responsible for account:

Phone: Email:

Signature: Name: Date:

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