

## Referral Form – Occupational Therapy

Thank you for your referral to *Hi Life Therapy & Care*. To ensure that we provide the best service to meet your needs, please complete this form with as much detail as possible. The OT Home Visit Risk Assessment (over page) *must* be completed for us to proceed with scheduling an appointment with the client.

Client Name	Click or tap here to enter text.		
Date of Birth	Click or tap to enter a date.	Gender	Click or tap here to enter text.
Address	Click or tap here to enter text.		
Contact Phone Number/s	Click or tap here to enter text.		
Contact Email Address <i>For appointment confirmation and invoicing</i>	Click or tap here to enter text.		
Support person required? <i>If 'Yes' please provide name, relationship and contact details</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Click or tap here to enter text.
Primary disability or concern	Click or tap here to enter text.		
Reason for requiring OT services <i>Please provide as much information as possible, to assist with referral process</i>	Click or tap here to enter text.		
Supporting Documents Attached? <i>This may include previous OT reports or medical/allied health reports or letters</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Any other information we should know?	Click or tap here to enter text.		

## OT Home Visit Risk Assessment

*Hi Life Therapy & Care is a community-based business and therefore all assessments/therapy sessions will be completed in your home environment. Please complete the below checklist to ensure the environment is suitable for our therapist/s to attend.*

1. Living situation (e.g., alone, with family, supported accommodation)	Click or tap here to enter text.	
2. Does the client live in an isolated area?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Is there mobile phone coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Are pets present? <i>Pets to be restrained whilst OT present.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Does anyone at the property have a history of being aggressive/violent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Does anyone at the property have a history of alcohol or illicit drug dependence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Does anyone at the property smoke or vape? <i>No smoking or vaping inside whilst OT present.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Are there firearms in the home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Does anyone at the property have an infectious disease/virus? <i>Please notify OT if anyone in the home becomes unwell prior to appointment.</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Are there any other factors relating to the safety of our therapists entering the property?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If home environment deemed unsuitable for assessment, please contact *Hi Life Therapy & Care* directly to discuss alternative arrangements.