Hi Life Therapy & Care
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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	
Date of Birth	Gender
Address	
Contact Phone Number/s	
Support person required? *If 'Yes' please provide name, relationship and contact details*	Yes ☐ No ☐
Plan or self-managed? **If NDIA-managed, we are unable to accept the referral at this time**	Plan-managed ☐ Self-managed ☐ *If plan-managed, please list plan agency details* Plan Manager Provider Name Plan Manager Email Address
NDIS Number	#
Primary Disability	
Reason for requiring OT services	
Support Coordinator/Local Area Coordinator Details	Name Email
NDIS Plan attached *If 'No', please provide NDIS goals*	Yes ☐ No ☐
Any other information we should know?	

OT Home Visit Risk Assessment

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

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