

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>of client or support person, for appointment reminders</i>			
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.		
Plan or self-managed? <i>*If NDIA-managed, we are unable to accept the referral at this time*</i>	Plan-managed <input type="checkbox"/>	Self-managed <input type="checkbox"/>	
	<i>If plan-managed, please list plan agency details</i>		
	Plan Manager Provider Name	Click or tap here to enter text.	
	Plan Manager Email Address	Click or tap here to enter text.	
NDIS Number	#	Click or tap here to enter text.	
Primary Disability	Click or tap here to enter text.		
Reason for requiring OT services	Click or tap here to enter text.		
Support Coordinator/Local Area Coordinator Details	Name	Click or tap here to enter text.	Email
			Click or tap here to enter text.
NDIS Plan attached <i>If 'No', please provide NDIS goals</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Click or tap here to enter text.		
Any other information we should know?	Click or tap here to enter text.		

OT Home Visit Risk Assessment

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.