OCCUPATIONAL THERAPY REFERRAL FORM

CLIENT DETAILS			
Title:	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:		
First name:		Surname:	
Preferred name (If applicable):		Aboriginal/Torres straits:	☐ Yes ☐ No
Date of birth:		Contact Number:	
Address:			
Email:			
Preferred language:		Translator/interpreter or communication aids required:	☐ Yes ☐ No
*Medical background: (Or attach GP health summary)			
Social information *(informal/formal support available)*			

NEXT-OF-KIN (NOK) / PRIMARY CARER / GUARDIAN DETAILS			
Full Name:		Contact Number:	
Relationship to client:			
Main contact to arrange service:	☐ NOK / Primary carer / Guardian ☐ Client	☐ Other:	

REFERRER DETAILS			
Name of referrer:		Tick this box if you are referring yourself: ☐	
Name of organization:		Job Title / Role:	
Contact number:		Email:	

BILLING DETAILS			
Name of person		Contact Number:	
Address			
Email invoices to:			

<table>
<tr><th colspan="6">REFERRAL REASON</th></tr>
<tr><td rowspan="2">Funding type:</td><td>Home care package:
☐ L1 ☐ L2
☐ L3 ☐ L4</td><td colspan="2">☐ Commonwealth Home Support Program (CHSP)</td><td>☐ Short term Restorative Care (STRC)</td><td>☐ Transition Care Package</td></tr>
<tr><td>☐ Privately funded</td><td>☐ Traffic Accident Commission (TAC)</td><td>☐ Other:</td><td colspan="2">☐ Flexible / limited Funding:
$_______________
(please specify amount)</td></tr>
<tr><td>Type of service required:</td><td colspan="5">☐ Equipment Prescription
☐ Home Safety Assessment
☐ Home Modification
☐ Electric Wheelchair or Scooter Assessment
☐ Activities of Daily Living (ADL) Retraining
☐ Upper Limb Retraining
☐ Education: ☐ Client ☐ Carer ☐ Family</td></tr>
<tr><td>Brief reason for referral:</td><td colspan="5"></td></tr>
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RISK ASSESSMENT			
Any person at premises exposed to COVID-19 in the last 7 days	☐ Yes	☐ No	☐ Unsure
Potential behaviour issues *(i.e. aggression, domestic violence, substance abuse)*	☐ Yes	☐ No	☐ Unsure
Is the client a smoker	☐ Yes	☐ No	☐ Unsure
Any pets at premises	☐ Yes	☐ No	☐ Unsure
Onsite parking / access issues	☐ Yes	☐ No	☐ Unsure
Is ongoing OT service required	☐ Yes	☐ No	☐ To be determined at visit
Other concerns or alerts:			

***Please return this completed form to:**
shellalim@joyfulhandsot.com.au

**Please note that the information provided above will form the contractual service agreement between Joyful Hands OT and the participant or their authorised representative.*