**OCCUPATIONAL THERAPY REFERRAL FORM**

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| **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)* |       |

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|  **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:   |

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

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

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| **REFERRAL REASON** |
| Funding type:  | Home care package: [ ]  L1 [ ]  L2 [ ]  L3 [ ]  L4 | [ ]  Commonwealth Home Support Program (CHSP) | [ ]  Short term Restorative Care (STRC)  | [ ]  Transition Care Package  |
| [ ]  Privately funded  | [ ]  Traffic Accident Commission (TAC)  | [ ]  Other: | [ ]  Flexible / limited Funding: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(please specify amount)* |
| Type of service required:  | [ ]  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  |
| Brief reason for referral:  |        |

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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.*