**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**](mailto: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.*