**REFERRER DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click or tap here to enter text. | **Organisation** | Click or tap here to enter text. |
| **Phone** | Click or tap here to enter text. | **Email** | Click or tap here to enter text. |
| **Role** | Click or tap here to enter text. | | |

**PARTICIPANT DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | Click or tap here to enter text. | | **D.O.B** | Click or tap to enter a date. | | |
| **Phone** | Click or tap here to enter text. | | **Gender** | Male  Female  Non-Binary  Preferred pronoun:  Click or tap here to enter text. | | |
| **Email** | Click or tap here to enter text. | | | | | |
| **Preferred method of contact** | | Choose an item. | | | | |
| **Address** | | Click or tap here to enter text. | | | | |
| **Suburb** | | Click or tap here to enter text. | | | **Postcode** | Click or tap here to enter text. |
| **Interpreter required** | | Yes  No  If yes, please outlined preferred language: Click or tap here to enter text. | | | | |
| **Contact person for making the appointment (name & number)** | | Click or tap here to enter text. | | | | |
| **Accepted NDIS Diagnosis** | | Click or tap here to enter text. | | | | |
| **Are supporting reports available for above accepted NDIS diagnosis?** | | Yes  No  If yes, please attach with this form. | | | | |
| **Additional Medical History – both physical and mental health (If applicable)** | | Click or tap here to enter text. | | | | |
| **Are supporting reports available for above additional medical conditions diagnosed?** | | Yes  No  If yes, please attach with this form. | | | | |
| **Person responsible for signing service agreement** | | Participant  Representative | | | | |

**PLAN DETAILS – PLEASE ATTACH COPY OF NDIS PLAN**

|  |  |  |  |
| --- | --- | --- | --- |
| **NDIS Number** | Click or tap here to enter text. | **Plan dates:** | Start date: Click or tap to enter a date.  End date: Click or tap to enter a date. |
| **How are plan funds managed?** | Agency Managed  Self-Managed  Plan Managed | | |
| **Funding Category** | Click or tap here to enter text. | | |
| **Funding available for Alpha Rehab:** | Click or tap here to enter text. | | |
| **Plan Manager Details** | | | |
| **Company Name** | Click or tap here to enter text. | | |
| **Contact Name** | Click or tap here to enter text. | | |
| **Contact Phone** | Click or tap here to enter text. | | |
| **Contact Email** | Click or tap here to enter text. | | |
| **Invoicing Details** | Click or tap here to enter text. | | |

**PARTICIPANT REPRESENTATIVE DETAILS (IF APPLICABLE)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click or tap here to enter text. | **Relationship to Participant** | Click or tap here to enter text. |
| **Phone** | Click or tap here to enter text. | **Email** | Click or tap here to enter text. |

**REASON FOR OCCUPATIONAL THERAPY REFERRAL**

|  |
| --- |
| Therapy Services (ongoing therapy)  Please detail: Click or tap here to enter text.  Functional Assessment and Report  Assistive Technology  SIL Assessment  SIL + SDA Assessment  Other: Click or tap here to enter text. |

**Additional Information (e.g. religious or cultural considerations, consultant and/or consultant gender preference, telehealth preference)**

|  |
| --- |
| Click or tap here to enter text. |

**Goals of NDIS Plan related to service request**

|  |
| --- |
| Click or tap here to enter text. |

**HEALTH SCREENING ASSESSMENT**

|  |  |
| --- | --- |
| **Has participant been admitted to hospital in the past 12 months?** | Yes  No  If yes, please state reason and length of admission:  Click or tap here to enter text. |
| **Has the Participant seen or been assessed by any medical specialists?** | Yes  No  If yes, please provide further details:  Click or tap here to enter text. |
| **Does the participant have any known allergies?** | Yes  No  If yes, please provide further details:  Click or tap here to enter text. |
| **Has the participant suffered any recent serious illness of injury?** | Yes  No  If yes, please provide further details:  Click or tap here to enter text. |

**SCREENING RISK ASSESSMENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Residence** | House  Unit  Office  Group home  Detention Centre  Hospital  Other: Click or tap here to enter text. | | | | |
| **Is parking available?** | Yes  No  Unknown | | | | |
| **Specific instructions to access the residence** | (e.g. pin code to apartment block, enter via side gate)  Click or tap here to enter text. | | | | |
| **OCCUPANT/S** | | **No** | **Yes** | **Unknown** | **If Yes, provide further information.** |
| Does the participant or other people in the home have a history of actual or threatened violence or aggressive behaviour? | |  |  |  | Click or tap here to enter text. |
| Does the participant have a positive behaviour support plan in place? | |  |  |  | Copy received:  Yes  No  If yes, please attach a copy. |
| Is it likely that any people within the home will be smoking or drinking alcohol during our visit? | |  |  |  | Click or tap here to enter text. |
| Is there known substance abuse amongst people who may be present? | |  |  |  | Click or tap here to enter text. |
| Are you aware of any occupant having an infectious disease? (e.g. COVID-19, chicken pox, shingles, gastro, MRSA) | |  |  |  | Click or tap here to enter text. |
| Are there any pets at the premises? | |  |  |  | Click or tap here to enter text. |
| **HAZARDS** | | **No** | **Yes** | **Unknown** |  |
| Are there any known weapons in the house? | |  |  |  | If yes, are they locked away?  Yes  No  Click or tap here to enter text. |
| Is there difficulty with mobile phone reception? | |  |  |  | Click or tap here to enter text. |
| Are there any potential hazards that you are aware of that would make access to this property difficult? (e.g. steps, house is hidden from the street, seasonal bushfire risk) | |  |  |  | Click or tap here to enter text. |
| **OTHER SAFETY CONCERNS** | | **No** | **Yes** | **Unknown** |  |
| Are there any other safety concerns we should be aware of? | |  |  |  | Click or tap here to enter text. |
| Is there a requirement for a Carer or Support Worker to be present at the time of the appointment? | |  |  |  | Click or tap here to enter text. |

Please email this completed referral form and any relevant documentation to [ben@alpharehab.](mailto:ben@alpharehab.)com.au. We will be in touch to discuss referral information and confirm next steps.