**ABILITY OT - REFERRAL FORM**

**Please email completed form and supporting documentation to** **admin@abilityot.com.au**

**Alternatively, call Laurel Conley (Admin Manager) on 0434 038 178 if you require assistance.**

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| **REFERRER DETAILS** |
| **Name of person who completed this form:** |  |
| **Date of Referral:** |  |
| **Referrer Name:** |  |
| **Organisation (if applicable):** |  |
| **Phone Number:** |  | **Email address:** |  |
| **CLIENT DETAILS** |
| **Client Name:**  |  |
| **Address:** |  | **Date of birth:****Age:** |  |
| **Phone Number:** |  | **Email address:** |  |
| **Next of Kin (if applicable):** | Name: Relationship:  | **Next of Kin contact details:** | Ph: Email:  |
| **Funding Source:** | [ ]  NDIS [ ]  Private Health [ ]  Self Funded [ ]  Workcover[ ]  RACQ [ ]  Suncorp [ ]  NIISQ[ ]  Other (specify): | **NDIS Plan Manager for Capacity Building:** | [ ]  SELF MANAGED [ ]  PLAN MANAGED [ ]  NDIA[ ]  COMBINATION |
| **Insurance or Claim or NDIS reference number:** |  |
| **NDIS Start Date:** |  | **NDIS End Date:** |  |
| **Insurer or NDIS Plan Manager details:** |  |
| **Support coordinator details (if applicable):** |  |
| **Medical Condition / Disability:**  |  |
| **REFERRAL REQUEST - *please tick which categories apply*** |
| [ ]  | Initial Needs Assessment (overview of current situation including AT/Equipment Needs) |
| [ ]  | Preparation for NDIS Application or Assistance with NDIS Plan Review Meeting |
| [ ]  | Minor Home Modification Assessment and Recommendations |
| [ ]  | Exploring Housing Options Assessment  |
| [ ]  | Vocational Return to Work Support |
| **HAS THE CLIENT PREVIOUSLY RECEIVED OCCUPATIONAL THERAPY? *If so, please provide as much relevant detail as possible and provide report/s if available*** |
|  |
| **CLIENT MEDICAL HISTORY - *please provide medical report/s if available*** |
|  |
| **SPECIFIC DETAILS OF REFERRAL REQUEST – *what does client require from an OT and what are their goals?*** |
|  |
| **RELEVANT DOCUMENTATION - *please attach for OT review*** |
| [ ]  Referral letter [ ]  Service discharge summary [ ]  Previous OT report [ ]  NDIS plan [ ]  NDIS goals [ ]  GP letter[ ]  Other: |
| **SAFETY CONSIDERATIONS**  |
| [ ]  Dog / animal on premises [ ]  History of violence [ ]  Environmental concerns [ ]  No safety considerations [ ]  Other: [ ]  Two person visit recommended? If yes, why? |
| **AUTHORISATION - *if applicable*** |
|  I certify that I have gained permission from the client / next of kin to make this referral.**Referrer Name: Referrer Signature: Date:**  |
| **OFFICE USE ONLY**  |
| **Date Received: Processed By: Designated Therapist:**  |