**ABILITY OT - REFERRAL FORM**

**Please email completed form and supporting documentation to** [**admin@abilityot.com.au**](mailto: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:** | | | |