**ABILITY OT – REFERRAL FORM**

**Please complete all sections of this form.**

Return completed form, NDIS Goals and any supporting documentation to [admin@abilityot.com.au](mailto:admin@abilityot.com.au)

If you require assistance, please call our Admin Team on 0434 038 178.

|  |  |  |
| --- | --- | --- |
| **Client Details** | | |
| **Client Name:** | Click or tap here to enter text. | |
| **DOB:** | Click or tap here to enter text. | |
| **Home Address:** | Click or tap here to enter text. | |
| **Contact number:** | Click or tap here to enter text. | |
| **Email address** | Click or tap here to enter text. | |
| **Referrer Details** | | |
| **Name:** | Click or tap here to enter text. | |
| **Relationship to client:** | Click or tap here to enter text. | |
| **Organisation:** | Click or tap here to enter text. | |
| **Phone number:** | Click or tap here to enter text. | Preferred contact method |
| **Email address:** | Click or tap here to enter text. | Preferred contact method |
| **Date of Referral:** | Click or tap here to enter text. | |

|  |
| --- |
| **Client Diagnoses / Relevant Medical History *(please be specific with condition)*** |
| Spinal Injury  Acquired Brain Injury  Parkinson’s Disease  Functional Neurological Disorder  Stroke  Multiple Sclerosis  Younger Onset Dementia  Complex conditions  Dual Diagnosis Other:  Date of Diagnosis / onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Reason for OT / Client Goals**  ***Please be as specific as possible for the therapy referred to NDIS participants, please also forward plan/goals.*** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Funding Source *(please select which funding arrangement best describes your situation)*** | | | | |
| **NDIS**  NDIS No.:  NDIS start date:  NDIS end date: | **RACQ**  **Suncorp**  **NIISQ**  **icare**  **TIO**  **Workcover**  Date of Injury:  Claim Number: | | **Private health insurer**  Fund:  Policy number: | Privately funded  Other (specify): |
| **NDIS Participant Details *(if applicable)*** | | | | |
| NDIA managed  Self-managed  Support Coordination  Plan managed  Nominee managed | | | | |
| **Plan Manger details:** | | Agency / Name:  Phone:  Email: | | |
| **Support Coordination / Nominee Details:** | | Name:  Relationship:  Address:  Phone:  Email: | | |

|  |  |
| --- | --- |
| **Appointment Contact *(who should we contact regarding appointments?)*** | |
| Client  Nominee  Support Coordinator | Name:  Relationship:  Phone:  Email: |
| **Emergency Contact / Next of Kin *(who should we contact in case of an emergency?)*** | |
| Appointment contact  Nominee | Name:  Relationship:  Phone:  Email: |

|  |  |
| --- | --- |
| **REFERRAL REQUEST - *please tick which categories apply*** | |
|  | Initial Needs Assessment with a view for Ongoing Capacity Building – includes a brief summary with recommendations *(overview of current situation including AT/equipment needs)* |
|  | Functional Capacity Assessment with report |
|  | Preparation for NDIS Application or Assistance with NDIS Plan Review Meeting. |
|  | Minor Home Modification Assessment and Recommendations |
|  | Exploring Housing Options Assessment *(includes care needs and accommodation recommendations)* |
|  | Vocational Return to Work Support |
|  | OT Driving Assessment |
| **Further Information relevant to referral request** | |
| **Current mobility status:**  Walking  Walking with aid  Wheelchair  Hoist transfers | |
| **HAS THE CLIENT RECEIVED MEDICAL TREATMENT OR ALLIED HEALTH THERAPY? *If so, please provide as much relevant detail as possible and provide report/s if available*** | |
|  | |
| **SAFETY CONSIDERATIONS – *regarding home visits*** | |
| 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:** | |

***When referring yourself or a client, please include*:**

Completed Ability OT Referral Form  NDIS Goals  Other Relevant Reports, Summaries, Letters.