**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

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

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| **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. |

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| **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.*** |
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| **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: |

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| **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: |

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| **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*** |
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| **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.