Referral Form

CLIENT DETAILS:

Surname:		Given name:	
Gender:		Interpreter required:	
Home address:		Postcode:	
Preferred phone:		Other phone:	
DOB:		Email:	
Diagnosis:		Do you identify as Indigenous, Aboriginal and/or Torres Strait Islander?	☐ Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Not Applicable ☐ Prefer not to answer
Additional information that may be helpful:			☐ Prefer not to answer
Communication ability:	Please describe (verbal / non-verbal / sign language / uses a device):		
Living arrangements:	Please describe (with family / independent / group home):		

ALTERNATE CONTACT/NOK/CARER/ADVOCATE/GUARDIAN:

Full Name:		Relationship to client:	
Address *(if different from above)*:		Postcode:	
Home phone:		Mobile phone:	
Email:			

FORM COMPLETED BY:

Full Name:		Phone:	
Relationship to client:		Date of referral:	

PLAN DETAILS:

NDIS Number:		NDIS Plan attached:	☐ Yes ☐ No
Plan start date:		Plan end date:	
Support Coordinator: *(if not listed above)*		Email:	

RISKS/HAZARDS:

Are there any dangers that we need to know about such as animals, behavioral concerns, firearms?	☐ Yes ☐ No
Please detail:	

PLEASE SELECT THE BOX YOU WOULD LIKE TO ASSISTANCE WITH

☐ **OCCUPATIONAL THERAPY (OT)**

Equipment Prescription	☐	**Please describe the client's needs and preferences:**	
Skill Development	☐		
Functional Assessment	☐		
Home Modifications	☐		
Other	☐		
Budget allocation for OT services:		**Improved Daily Living** 15_056_0128_1_3 Assessment, Recommendation, Therapy And/Or Training (incl. AT)	**Hours** __________
		Other Line Item _________________________	**Hours** __________
How is the funding category managed?	☐ NDIA ☐ Plan ☐ Self	Plan/Self manager details *(if applicable)*:	**Name:** **Contact Number:** **Email:**

Please complete all information and email to: admin@launcestonalliedhealth.com

1) OFFICE USE ONLY:			
Referral received by:		**Date:**	
Referral sent to:		**Date:**	