Referral Form - Occupational Therapy

ILCSA INDEPENDENT LIVING CENTRE SA

REFERRAL FOR OCCUPATIONAL THERAPY

Surname:		**First:**	
Title:	**DOB:**	**Gender:**	**Pets on premises:**
Address:			
Suburb:		**Postcode:**	
Fund Number: [ ] HCP [ ] DVA [ ] Self funded [ ] NDIS #No:			
Level of Funding (HCP)			
Mobile:		**Home Ph:**	
Email Address:			
Alternate Contact: **Alternate Phone:**		[ ] Contacted to arrange consult [ ] Alternate required at consult (client	
Alternate Contact's relationship to client: [ ] Family _____ [ ] Friend [ ] Support Coordinator [ ] Case Manager [ ] Legal Guardian		consents) Name: _____ Email: _____	
Preferred Language: Communication support required:		_____ [ ] Family interpreter [ ] Interpreter Required N/A	
Medical History / Condition/s:			

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Occupational Therapy assessment & reports - Tick applicable [ ] Full Occupational Therapy assessment & report [ ] Home Modifications [ ] Assistive Technology (equipment) [ ] Home Safety / Falls Risk Assessment	[ ] ADL / Functional Assessment [ ] Manual Handling Plan [ ] Vehicle Modifications [ ] Driver Re-education [ ] Care Needs Assessment [ ] Other - specify below

Referral request details / Plan / Goals: *Please provide as much information as possible.*

Has a risk assessment been completed? [ ] YES [ ] NO **Copy of risk assessment and factors are provided to OT** [x] YES
Advise ILCSA o f any Risks i.e: Violence; Sexual risk; Self Harm; Aggression;Drug / Alcohol abuse;Safety Issues; Limited access to the property; Hoarding / pest or rodent infestation.

Name of person / organisation responsible for the account/ invoice: **Email:**	**Phone No:**
REFERRER SIGNED:	**Phone:** **Role:**
Referrer Name:	**Email:**