OCCUPATIONAL THERAPY REFERRAL FORM

opportunOTy

PLEASE COMPLETE AND RETURN FORM TO US AT:
welcome@oppot.com.au

Referrer / Support Coordinator: Please complete the below as much as possible.
Any elements unable to be completed will be completed with therapist on initial visit.

***Firstly*, is the participant aware of the submission of this referral? Yes ☐ No ☐**

PARTICIPANT DETAILS	
First Name:	**Surname:**
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female** ☐ **Non-binary**
Residential Address: **Postal address (if different from above):**	
Email address:	
Home number:	**Mobile number:**
Language spoken at home:	
Interpreter required? ☐ **Yes** ☐ **No**	
Do you identify as Aboriginal or Torres Strait Islander? ☐ **Yes** ☐ **No**	

COMMUNICATION	
Preferred option for communication: ☐ **Email** ☐ **Phone call** ☐ **Text**	
Best client contact:	
Notice period required for appointments: ☐ **24 hours** ☐ **48 hours**	☐ **1 week** ☐ **2 weeks**
Who is responsible for approving the Service Agreement? i.e. participant, responsible decision maker, support coordinator, other.	

INITIAL ASSESSMENT

Preferred place of initial assessment (e.g. in home, in clinic):

People to be present during initial assessment i.e. family member, advocate, support person, other:

PREFERENCES

Preferred name:

Religious requirements:

Cultural requirements:

Communication device: ☐ **Yes** ☐ **No**

Allergies:

NDIS PLAN

Do you have an approved NDIS plan? ☐ **Yes** ☐ **No**

☐ **NDIS Managed -** *Please Note: A 3hour service booking will be completed within the portal prior to the first visit to ensure funding availability.* A copy of the NDIS plan **MUST BE** provided for NDIS managed participants.

☐ **Self-Managed**

☐ **Plan-Managed**

NDIS number:

NDIS start date:

NDIS end date:

PLEASE PROVIDE DETAILS FOR INVOICES

Name:

Email:

Comments:

FUNDING

If Minor Assistive Technology (Equipment) is part of the funded supports, which funding category is this to be drawn from?

☐ Core Supports ☐ Assistive Technology

If Hire Assistive Technology (Equipment) is part of the funded supports, which funding category is this to be drawn from?

☐ Core Supports ☐ Assistive Technology

In addition to the participant, is authorisation required from other parties, prior to use of Equipment Funding?

☐ Support coordinator

☐ Plan manager

☐ Significant other

☐ Guardian (OPG)

☐ Other _____

Due to workplace health and safety legislation and the volume of information gathered, two therapists are required for the first visit. The invoice for the first visit will include the two therapists' time.

PARTICIPANT GOALS – What does the participant want to achieve – e.g. life skills, SIL report, SDA report, equipment, physical, social, etc?

SERVICES REQUIRED

☐ Assessment and functional report required as soon as possible (e.g. change of circumstances)

☐ End of plan functional review report

☐ Ongoing therapy

Is there a Guardianship and/or Administration order in place? ☐ **Yes** ☐ **No**
Name of Guardian:
Phone:
Email:

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers, please complete below.

Name of parent/guardian 1:	
Relationship to participant:	**Emergency contact:** ☐ **Yes** ☐ **No**
Primary carer: ☐ **Yes** ☐ **No**	**Lives with participant:** ☐ **Yes** ☐ **No**
Address:	
Email address:	
Home number:	**Mobile number:**
Name of parent/guardian 2:	
Relationship to participant:	**Emergency contact:** ☐ **Yes** ☐ **No**
Primary carer: ☐ **Yes** ☐ **No**	**Lives with participant:** ☐ **Yes** ☐ **No**
Address:	
Email address:	
Home number:	**Mobile number:**

DISABILITY & MEDICAL CONDITONS – INCLUDING DIAGNOSIS IF RELEVANT
1.
2.
3.
4.
5.

Please provide all relevant medical and other AHP reports via email or have ready with you at first appointment.

HEALTH CARE INFORMATION
Doctor name:
Clinic name:
Phone number:

OTHER SERVICE PROVIDERS CURRENTLY USING
Name/organisation:
Phone number/email:
Name/organisation:
Phone number/email:
Name/organisation:
Phone number/email:

RISK ASSESSMENT
Is there a history of behaviours? (e.g. sexual, aggressive, violent)? ☐ **Yes** ☐ **No** ***If you answered yes, please explain:***
Is anyone living at the premises known to be potentially aggressive or violent? ☐ **Yes** ☐ **No** ***If you answered yes, please explain:***

Is there any observable evidence that the participant/other occupants are involved in substance abuse?

☐ Yes ☐ No

If you answered yes, please explain:

Is there any evidence that weapons (e.g. guns) are on the premises?

☐ Yes ☐ No

If you answered yes, please explain:

Does any occupant have or has been recently exposed to an infectious disease, e.g. chicken pox, shingles, influenza, gastro?

☐ Yes ☐ No

If you answered yes, please explain:

Are there any pets/animals on the premises?

☐ Yes ☐ No

If you answered yes, please explain:

Are the clients or others living at the premise's smokers?

☐ Yes ☐ No

If you answered yes, please explain:

Is there any difficulty with mobile phone coverage and/or a working land line?

☐ Yes ☐ No

If you answered yes, please explain:

Is there adequate parking on the street? ☐ **Yes** ☐ **No** ***If you answered yes, please explain:***
Are there any access problems, e.g. (automatic door, gate key)? ☐ **Yes** ☐ **No** ***If you answered yes, please explain:***

Therapist to review and have participant sign on initial visit:

I understand that:

- These records are owned by this organisation.
- Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties
- I can ask to see records and receive a copy
- Records are archived for a set period according to policy and procedure
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: _____

Name: _____ Date: _____

Relationship to participant: _____