



OCCUPATIONAL THERAPY REFERRAL FORM

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.

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 1 week
 48 hours 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



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: _____

