COMMUNITY OT REFERRAL FORM

Thank you for your referral to Community Occupational Therapy. To ensure we provide the best service and most appropriate Occupational Therapist to meet your needs please complete the following form in as much detail as possible.

Client Details		
Name:	**DOB:**	**Phone:**
Address:		**Email:**
NOK contact details and relationship:		**Gender:**
Primary Diagnosis/ Disability and Reason for Occupational Therapy Referral:		

Referrer Details (Please tick your role)					
Name:			**Phone:**		
Organisation (if applicable:			**Email:**		
Self ☐	**Family** ☐	**Case Manager** ☐	**OT** ☐	**Allied Health** ☐	**Other** ☐

Reason for Referral (please tick)		
☐ **Home Modifications**	☐ **Home Assessment**	☐ **Functional Assessment**
☐ **Equipment Prescription**	☐ **Driving Assessment**	☐ **Ongoing Therapy**
Other:		

OT Home Visit Risk Assessment (Please complete accurately to ensure safety of our therapists entering the home of the client)	
1. **Living situation** (eg. alone, family, supported accommodation)	
2. Does the client live in an isolated area?	
3. Is there mobile phone coverage?	
4. Are pets present? (Pets to be restrained at time of assessment)	
5. Does anyone at the property have a history of being aggressive/ violent?	
6. Does anyone at the property have a history of alcohol or illicit drug dependence?	
7. Are there firearms in the home?	
8. Does anyone at the property have an infectious disease?	
9. Are there any other factors relating to the safety of our therapists entering the property?	

Billing			
How many hours or visits do you require approximately? Please discuss with Lucy if unsure.			
Who is responsible for payment:	☐ Self	☐ Care Package	☐ DVA
	☐ TAC	☐ Worksafe	☐ Other

Any other information you think we should know?

Please return this form ASAP to Lucy via email admin@communityot.com.au or fax 9388 9793 so we can arrange your Occupational Therapist to attend your home.