Abraham OT Services Pty Ltd
ABN 53 247 359 828

PO Box 4053, Wishart VIC 3189
Tel 03 9555 0303
Fax 03 9553 2208
Email admin@aots.com.au

New Client Referral Form

Date of referral:

Urgency of referral **Normal** ◯ **Urgent** ◯

Personal information:

Mr/Mrs/Ms/Miss/Master Ms

Preferred ProNoun: **He/Him** ◯ **She/Her** ◯ **Other** ◯

PLEASE PROVIDE FULL LEGAL NAMES.

First Name:

Last Name:

Preferred Name to be called:

Address:

Is this address a Nursing Home or an Aged Care Facility? YES ☐ NO ☐

Postcode:

D.O.B:

Phone Contacts:

Email Address:

Next of Kin Details:

(Person to contact in an Emergency)

First Name:

Last Name:

Relationship to Client:

OCCUPATIONAL THERAPY

Funding: OTHER

If Other, Please give details:

For NDIS – *Package Number:*

Select Billing Method: Self Manage

Plan Manager Company: **Phone contact:**

Email:

Support Coordinator Name:

Phone Contact: **Email**:

For **TAC**, advise **Claim Number:**

Current Case Manager Name:

Phone: **Email:**

For DVA, Advise Card Number and status: White ◯ Gold ◯

IMPORTANT – MUST be completed:

MEDICAL HISTORY:

Please provide a summary of the client's Current **AND** Previous medical history:

Please tick ANY of the applicable boxes below and provide details:

- ☐ ABI
- ☐ Stroke
- ☐ Spinal cord injury
- ☐ Neurological condition
- ☐ Dementia
- ☐ Bi Polar / Schizophrenia Disorder
- ☐ Depression / Anxiety Disorder
- ☐ Autism Spectrum
- ☐ Neurodevelopmental Disorder
- ☐ Intellectual Disability
- ☐ Other Mental Health Diagnosis

Provide FULL Details:

Have they ever had OR currently have an infectious disease? YES ☐ NO ☐
If yes, please provide FULL Details.

Mobility Status:

Cognitive Issues or concerns: (Memory, learning, perception, etc)

Behavioural issues (Including any Personality disorders):

Can the person communicate directly: YES ☐ NO ☐

Can the person understand written English: YES ☐ NO ☐

Interpreter required: ☐ **YES** ☐ **NO** **Language:**

Presenting issues/ concerns and reason for referral:

Please tick applicable boxes below and Provide as much details as possible:

☐ Home Modifications assessment

☐ Carer assessment and/or carer training

☐ Equipment review/assessment/ prescription Postural seating assessment

☐ Full OT Assessment

☐ ADL's Training (Activities of Daily Living)

☐ SDA Assessment

☐ Pressure care assessment / review

Give Full Details below:

Other services currently involved in therapy/treatment:

ie. Physiotherapist, Speech therapist, neuropsychologist.

I Give AOTS the authority to speak with ANY of my service providers during the period of support in this agreement. ☐ **YES** ☐ **NO**

Referrer's Details:

Name:

Email:

Contact Number:

Relationship to Client:

Person to speak to for initial contact (*If other than the client)*

Name:

Phone Number:

Which of the following do you require Post visit? Other

Terms:

1. Payment in full is required within 14 days of receipt of invoice
2. The client will accept full liability for NDIS, Worksafe, TAC and DVA claims which are rejected
3. Should payment remain outstanding beyond 21 days, the client is liable for all costs including legal costs (on a solicitor/own client basis) and Mercantile Agents fees incurred by Abraham OT Services Pty Ltd.
4. Accounts overdue by more than 60 days will be subject to interest of 2% per month from the date payment due until the date payment is made.
5. Cancellation of sessions need to be made more than 24 hours prior to appointment. Failure to do so will still incur the standard fee.
6. **NDIS invoices** will be submitted to:
client directly (If self managed), or via Financial Plan Managers or
Agency Managed – NDIS Portal

Name:

Signature:

Relationship to client:

Date:

By signing this form you Acknowledge and accept the above terms.

DO you require an Advocate to be present during Any or ALL of the therapy sessions or phone calls with the Occupational Therapist? YES ☐ NO ☐

IF YES, please provide FULL Details:

Home Safety Assessment:

Must be completed In FULL for the safety of our Occupational Therapists

	YES	NO	Comments
Is there street or driveway parking available?	☐	☐	
Are there any obstacles to the access of the property?	☐	☐	
Is there an access code to enter the property?	☐	☐	
Are there weapons or firearms on the property?	☐	☐	
Any pets inside the home? (Can they be restrained for the visit?)	☐	☐	
Any smokers in the home? (We ask that smokers please refrain from Smoking during the visit period)	☐	☐	
Will there be other people present during the visit?	☐	☐	
Will you require an Advocate to be present during the visit? (Either for legal or cultural or Language reasons)	☐	☐	
Are there any person in the home (which will be present during the visit) that could possibly present a security risk to our employee? (*History of violent behaviour, IV Drug user, alcohol abuse, etc*)	☐	☐	
Do you require assistance with transfers? If YES, will there be a carer or support worker present to assist?	☐	☐	