Abraham OT Services Pty Ltd
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New Client Referral Form for Support Coordination

Please note - this referral form must be completed in full to be assessed for service

Date of referral:

Client Details

Mr/Mrs/Ms/Miss/ Mr

Master Preferred **He/Him** ☐ **She/Her** ☐ **They/Them** ☐

Pronoun:

PLEASE PROVIDE FULL LEGAL NAMES.

First Name:

Last Name:

Preferred Name:

Address:

Postcode:

D.O.B:

Phone Contacts:

Email Address:

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

Next of Kin Details:

(Person to contact in an Emergency)

First Name:

Last Name:

Relationship to Client: **Contact Number:**

Package Details

Funding:	NDIS
NDIS Number:	
NDIS Plan Dates:	
Number of hours available/approved:	
Select Billing Method:	Plan Managed
Plan Management Company:	
Phone:	
Email:	
Current Support Coordinator Name: (if applicable)	
Phone:	
Email:	
If 'Other' chosen for funding, please give details:	

Medical History

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

Please tick all 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
- ☐ Intellectual Disability
- ☐ Other - please specify

What are the Clients presenting issues and how does this impact on their functioning? Please provide some history on the client's current situation including their family history, social supports, and cultural considerations: Please note any risks of self-harm, suicidal ideation, harm to others, substances use, housing, or legal issues.

Has the person being referred ever had, OR do they currently have, an infectious disease? If yes, please provide FULL Details. **YES** ☐ **NO** ☐

Mobility Status:

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

Behavioural issues (Including any Personality disorders):

Can the person communicate directly: Can **YES** ☐ **NO** ☐

the person understand written English: **YES** ☐ **NO** ☐

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

Do you have any ethnic or religious beliefs you need us to be aware of? Yes ☐ No ☐

If yes, please provide details

Reason For Referral

Referred for:

- ☐ General Support
- ☐ Implementation of New
- ☐ Plan NDIS Plan Review
- ☐ SDA/SIL/ILO Reports
- ☐ Change of Circumstance Review
- ☐ Assistance to acquire New Services
- ☐ Assistance with access to NDIS (privately funded)

Services that our Support Coordinator will work with:

Support	Name	Contact Details - email/phone
Occupational Therapist		
Physiotherapist		
Speech Therapist		
Psychologist		
Neuropsycologist		
Other (please specify)		

I give AOTS the authority to speak with any of my service providers during the period of support as agreed by all parties

YES ☐ **NO** ☐

Referrer Details

Name:

Email:

Contact Number:

Relationship to Client:

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

Name:

Phone Number:

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 that 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 must be made at least 48 hours prior to appointment. AOTS reserve the right to charge the full standard fee for failure to cancel your session within this time.**
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 phone calls with the Support Coordinator?

YES ☐ **NO** ☐

If YES, please provide full details of Advocate:

Home Visit Safety Checklist

For the safety of our staff, it is mandatory this document is completed in full and uploaded on to Iinsight when Client details are entered.

Name: _____ DOB: _____

Address: _____

Phone: _____

Person answering questions: _____

Completed by: _____ Date: _____

	Yes	N	Comments
Are there any obstacles in order to access the property? Is there an access code to enter the premises?	☐	☐	
Is there driveway OR street parking at this address?	☐	☐	
Any pets inside the home? **Can the animal be restrained for the duration of the home visit?**	☐	☐	
Will you require an Advocate be present during the visit/s? ***(Either for legal, cultural or language reasons?)***	☐	☐	
Will any be other people present during the visit? ***Carers, support workers, family or friends?***	☐	☐	
Are there any persons in the home who will be present during the visit that could pose a security risk to our employee? ***(History of violent behaviour, IV Drug user, etc..?)***	☐	☐	
Are there any firearms or weapons in the premises?	☐	☐	
Are you aware of any occupant having an infectious disease (***i.e. chicken pox/ shingles/ gastro, etc.)?***	☐	☐	
Any smokers in the premises? **We ask that smokers please refrain from smoking inside the house during the visit period**	☐	☐	
Do you require assistance with transfers? *If **YES**, will there be a carer or support person there to assist?*	☐	☐	
If a TeleHealth meeting / assessment is Arranged in lieu of a face to face visit, will there be a quiet & private place to conduct this meeting (either via phone call or video call) ?	☐	☐	