Abraham OT Services Pty Ltd
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New Occupational Therapy Client Referral Form

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

Date of referral:

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

**** Without this information your referral will not be accepted**

Client Details

Mr/Mrs/Ms/Miss/Master Mr

Preferred Pronoun: **He/Him** ☐ **She/Her** ☐ **They/Them** ☐

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: **
(please note if you are privately funded AOTS will invoice you for 50% of the hours required to achieve your goals, this must be paid in full prior to your initial assessment)

☐ NDIS ☐ TAC ☐ DVA
☐ Private ☐ Aged Care

Claim or Package Number: **

NDIS Plan Dates: **

Number of hours available/approved: **

Select Billing Method: **

☐ Plan Managed ☐ Individualised Funding
☐ Self Managed ☐ Private Health
☐ Agency Managed ☐ Other

Plan Manager Company: **

Phone:

Email:

Support Coordinator Name: **

Phone: **

Email: **

Medical History

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

Primary Diagnosis: **

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

☐ ABI
☐ Stroke
☐ Neurological Condition
☐ Spinal Cord Injury
☐ Dementia
☐ Depression / Anxiety Disorder
☐ Bi Polar / Schizophrenia Disorder
☐ Other - Please specify
☐ Autism Spectrum
☐ Neurodevelopmental Disorder
☐ Intellectual Disability

Please provide detailed medical history below **

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

Mobility and Transfer 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:**

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

If yes, please provide details

Service Request - please provide details of the service you require

- ☐ Upper Limb Robotic Therapy
- ☐ Lower Limb Robotic Therapy
- ☐ COPE Assessment
- ☐ Activities of Daily Living Retraining
- ☐ Carer Training and/or Carer Assessment
- ☐ Full OT Assessment
- ☐ Home Modifications Assessment
- ☐ Equipment Assessment and Prescription
- ☐ Pressure Care Assessment
- ☐ SDA Assessment
- ☐ SIL Assessment

Please give reason for referral 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 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. If you are a privately funded community client, AOTS reserves the right to invoice you for 50% of the hours estimated for you to achieve your goals, this must be paid in full prior to your initial assessment
3. If you are a privately funded clinic client, you will be charged for your appointment at the conclusion of your therapy session
4. If you are a privately funded clinic client attending for intensive therapy, you will be charged in advance for your therapy, this must be paid in full prior to your intensive therapy commencing
5. The client will accept full liability for NDIS, Worksafe, TAC and DVA claims that are rejected
6. 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.
7. 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
8. 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.
9. NDIS invoices will be submitted to the client directly (if self-managed), or via Financial Plan Managers (if Plan Managed) or NDIS Portal (if Agency Managed)

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 of Advocate:

Home Safety Checklist

For the safety of our staff, this document must be completed in full prior to us visiting you.

Name: **DOB:**

Address:

Phone:

Person answering questions:

Completed by: Date:

	Yes	No	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 to 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 people 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. COVID, chicken pox/shingles, Gastro, MRSA 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) ?	☐	☐	