

OT Referral Form: HCP/SAH Participants



PLEASE COMPLETE ALL SECTIONS OF THE FORM

Participant Details		
Name	Click or tap here to enter text.	
Date of Birth	Click or tap here to enter text.	
Email	Click or tap here to enter text.	
Contact Number	Click or tap here to enter text.	
Address	Click or tap here to enter text.	
Next of Kin: Name/Ph	Click or tap here to enter text.	
Plan Details	Click or tap here to enter text.	
Package Provider		
Level of Package	☐ Level 1	☐ Level 5
	☐ Level 2	☐ Level 6
	☐ Level 3	☐ Level 7
	☐ Level 4	☐ Level 8
Case Manager Name	Click or tap here to enter text.	
Case Manager Email	Click or tap here to enter text.	
Provider Email – invoices to be sent to	Click or tap here to enter text.	
Referral Information	Click or tap here to enter text.	
Relevant Medical History	Click or tap here to enter text.	
Reason for Referral		
(Kindly TICK at least ONE of the boxes)		
Occupational Therapy Evaluation / Assessment The client is needing an assessment from an occupational therapist to evaluate, justify and recommend necessary supports.	☐ Initial / Full Assessment <i>This is a standard evaluation of the client and the client's home which could lead to assistive technology prescriptions and/or home modifications. OT will assess the client's functional capacity and discuss all possible equipment and home adaptations to assist the client.</i>	☐ Follow-Up Assessment <i>This is an evaluation requested when the client already has the assistive technology prescribed and/or the home modification completed or is needing a re-evaluation due to changes in capacity and circumstances.</i>
Assistive Technology Prescription and Trials The client has already been seen by an Allied Health Professional and has an idea of which assistive technology / equipment he/she needs. This assessment will focus on which AT/equipment is most suitable for the client.	☐ Low-Cost AT/Equipment <i>This includes but is not limited to fall prevention equipment, adaptive bathroom/kitchen/dining items, manual wheelchairs, walking aids.</i>	☐ Mid-/High-Cost AT/Equipment <i>This includes but is not limited to electric beds, electric lift recliners, mobility scooters.</i>
Allocated Funding Available for Equipment Prescription	\$	
Home Modifications/Adaptations The client has already been seen by an Allied Health Professional and has an idea of which assistive technology / equipment he/she needs. This assessment will focus	☐ Minor Home Modifications <i>This includes but is not limited to grab rails and rubber ramps.</i>	☐ Major Home Modifications <i>This includes but is not limited to timber ramps, electric bidets, and replacing/widening shower.</i>

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on which AT/equipment is most suitable for the client.		
Allocated Funding Available for Home Modifications	\$	
Service Booking and Agreement		
Are in-home services required?	☐ Yes	☐ No
Available Funding/Hours	Click or tap here to enter text. <i>If unsure an initial appointment will be booked, and support frequency recommended. A service agreement/schedule of supports will then be provided once funding confirmed.</i>	
Referrer Information		
Name of Referrer	Click or tap here to enter text.	
Role	Click or tap here to enter text.	
Contact Number	Click or tap here to enter text.	
Email	Click or tap here to enter text.	

Please complete form thoroughly and send to admin@compassrehab.com.au. If you are unable to complete the form or have any questions, please call 07 4112 4446.