OPTIMISE
occupational therapy
...optimise living

Please forward referral to: Fax: 8275 2872 or
PO Box 432 BRIGHTON SA 5048

REFERRAL FORM

Client Details:

Surname: _____ Given Names: _____

D.O.B: _____ Gender: Male ☐ Female ☐

Address: _____ Post Code: _____

Home Number: _____ Mobile Number: _____

Location of Client: Home ☐ Hospital ☐ Hospital: _____ Discharge Date: _____

Private Health Insurance Status: DVA Status:

Health Fund: _____ White Card ☐ Gold Card ☐

Membership Number: _____ DVA Card Number: _____

Please contact your Health Fund to confirm you are covered for Occupational Therapy Services under your premium.

Contact Details:

Contact Person: (if different from client)

Name: _____ Relationship: _____ Phone Number: _____

Referrers Details:

Name: _____ Profession: _____

Organisation: _____

Phone Number: _____

Provider Stamp:

Address: _____ Post Code:_____

Signature: _____ Date Signed: _____

GP Details:

GP Name: _____ Practice Name: _____

Practice Address: _____

Phone Number: _____

Has the client consented to the referral? Yes ☐ No ☐

Please ensure that the client is aware of all information provided in the referral.

Office Use:

Date Received: ORN: Occupational Therapist:

PO Box 432 BRIGHTON SA 5048 Phone: 0403 158 964 Fax: 8275 2872 Email: info@optimiseot.com.au
www.optimiseot.com.au

Requested Occupational Therapy Service: _____

_____

_____

Diagnosis: _____

Past Medical History: _____

_____

Allergies: _____ Infection Status:_____

Social situation: _____

Level of Functional Independence: (independence or required level of assistance)

Mobility: _____ Aids Used: _____

Transfers: _____

Self Care: (e.g. eating, dressing, bathing) _____

_____

Domestic and Community Living Skills: (e.g. household duties, shopping, managing money, transport etc) _____

_____

Education/Employment/Recreation Status: _____

Drivers Licence Status:

No Licence ☐ Current Licence ☐ Temporarily Suspended ☐ Cancelled ☐

Functional Performance Skills:

Physical: (e.g. balance, upper limb, lower limb, coordination etc) _____

_____

_____

Sensory: (e.g. vision, hearing, sensory impairments etc) _____

_____

Cognition/Perception: (attention/concentration, speed of processing, problem solving, memory, visuospatial abilities) _____

_____

Speech/Language: _____

_____

Psychological/Emotional: _____

_____