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| Occupational Therapy Services Referral Form |  |

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The following services are requested (please tick):

|  |  |
| --- | --- |
| [ ]  Activities of Daily Living Assessment & Retraining | [ ]  Workplace Assessment |
| [ ]  Home Assessment | [ ]  Office Ergonomic Assessment |
| [ ]  Minor Home Modifications | [ ]  Equipment Prescription |
| [ ]  Support Needs Assessment | [ ]  Return to Work Case Management |
| [ ]  Equipment Assessment & Prescription | [ ]  Manual Handling Training |
| [ ]  Cognitive Rehabilitation | [ ]  Functional Capacity Assessment |
| [ ]  Wheelchair Prescription [ ]  manual [ ]  power | [ ]  Task Analysis |
| [ ]  Brainwave - R | [ ]  Other:       |

Referral Details

|  |  |  |  |
| --- | --- | --- | --- |
| Client’s Name: |       | Date of Birth: |       |
| Address: |       |
| Telephone: |       | Date of Injury: |       |
| Nature of Disability/ Injury: |       |
| Background information: *(eg. purpose of referral, functional difficulties, social situation). Please also attach all relevant reports.* |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurer: |       | Claim No: |       |
| Insurer Contact: |       |
| Email / Phone: |       |

|  |  |
| --- | --- |
| General Practitioner: |       |
| Address: |       |
| Email / Phone: |       |

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| --- | --- |
| Please advise who/where to direct invoices to: |       |

Referrer Details

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Phone: |       |
| Agency: |       | Email: |       |
| Role: |       |  |       |
| Signature: |       | Date: |       |

Please forward this referral form to OT Rehab Services via email to contact@otrehabservices.com.au