REFERRAL FORM

Date of Referral _____

Customer Details

This is the person who will be receiving services

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other _____ Date of Birth: _____

First Name(s): _____ Surname: _____

Residential Address: _____

Postal Address (if different): _____

Email: _____

Home Phone: _____ Mobile: _____

Health and/or Safety Concerns (e.g. pets, immunocompromised etc.): _____

_____

Will the customer or a support person be able to use a mobile phone and/or video conferencing technology to assist with conducting an assessment in the case of a COVID lockdown or other unforeseen circumstances? ☐ Yes ☐ No

Customer Availability

Please note TADWA is open Monday to Friday and does not conduct any assessments or complete any work on weekend days. TADWA Occupational Therapists conduct assessments in the morning only (between 8:30 am and 12:30 pm) and TADWA technicians generally work from 7 am to 3 pm.

Please indicate below any customer preferences for days and times for assessments, onsite visits, installations etc. Please note we may not always be able to accommodate preferences but will endeavour to do so wherever possible.

☐ Monday AM ☐ Monday PM ☐ Tuesday AM ☐ Tuesday PM ☐ Wednesday AM

☐ Wednesday PM ☐ Thursday AM ☐ Thursday PM ☐ Friday AM ☐ Friday PM

Carer, Representative, Advocate or Family Details

If not applicable please go to the next section

Full name: _____ Relationship to Customer: _____

Organisation *(leave blank if not applicable)*: _____

Address: _____

Email: _____

Phone: _____ Mobile: _____

Is this person required to be present to support the customer during any assessments or onsite visits?

⬜ Yes ⬜ No

Customer's Diagnosis / Health Condition *Please provide relevant details*

_____

_____

Equipment Currently Used *Please provide relevant details*

_____

_____

Other Supports or Providers

e.g. Occupational Therapist (OT), Physiotherapist, Care or Support Workers, additional Family Members

Full name: _____ Role or Relationship to Customer: _____

Email: _____

Phone: _____ Mobile: _____

Full name: _____ Role or Relationship to Customer: _____

Email: _____

Phone: _____ Mobile: _____

Service(s) Requested

Therapy Services: Occupational Therapy

- ☐ Home Environment Assessment
- ☐ Assessment for equipment or assistive technology
- ☐ Skills Training
- ☐ Transfer Training
- ☐ Self Care Assessment
- ☐ Showering Assessment (with carer)
- ☐ Other: _____

Home Modifications

- ☐ General
- ☐ Bathroom
- ☐ Kitchen
- ☐ Other: _____

TACS (Technology and Computer Services)

- ☐ Mobile Pendant Alarm
- ☐ Refurbished Technology Equipment
- ☐ Konnekt Video Service
- ☐ New Technology Equipment
- ☐ Tech Support Agreement
- ☐ Other: _____

Recreation and Mobility

- ☐ Freedom Wheels
- ☐ Silver Wheels (65+)
- ☐ Other: _____

Vehicle Mobility

- ☐ Hand Controls
- ☐ Left Foot Accelerator
- ☐ Wheel Chair Hoist
- ☐ Other: _____

Custom Solutions

- ☐ Other: _____

_____

Billing / Funding Details

⬜ Self Funded ⬜ NDIS ⬜ EFL Grant ⬜ Home Care Package

⬜ Other _____

Person or Organisation Responsible for Invoice *(if different from Customer)*

Name / Organisation: _____

Billing Address: _____

Email: _____ Phone: _____

NDIS Number: _____ NDIS Plan Dates: _____

Send to referrals@tadwa.org.au for TADWA Head Office
or bunbury@tadwa.org.au for TADWA Bunbury