Occupational Therapy Services

Referral Form for HCP and Self Funded Clients

Technology for Ageing & Disability

Date of Referral: _____

SERVICES REQUIRED

If an OT assessment has already been completed, please use the form titled 'GEAT, Home Modifications, Vehicle Modifications and Technology'.

☐ Initial Assessment & Home Environment Report

☐ Subsequent Consultation *(Only available if initial assessment has been completed within the last 12 months)*

☐ Assessment for Mobility Scooter/ Electric Wheelchair

☐ Therapy@Home ☐ Building Consultancy ☐ Building & Design Construction

CUSTOMER DETAILS

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

First Name(s): _____ Last Name: _____

Residential Address: _____

Postal Address (if different): _____

Email: _____

Home Phone: _____ Mobile: _____

Main Language Spoken: _____ Interpreter Required: ☐ Yes ☐ No

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

CUSTOMER DIAGNOSIS/ HEALTH CONDITIONS/ GOALS

This is important to help us triage the best OT for the customer, and customers may not always remember their diagnoses.

Is the customer receiving care from any palliative care teams: ☐ Yes ☐ No

EQUIPMENT CURRENTLY USED

HCP PROVIDER/ CARER/ REPRESENTATIVE OR ADVOCATE DETAILS

Full Name: _____

Relationship to Customer: _____

Organisation: _____

Address: _____

Email: _____

Home Phone: _____ Mobile: _____

Is this person required to be present to support the customer during assessments/ onsite visits:

☐ Yes ☐ No

OTHER SUPPORTS OR PROVIDERS

E.g. Physiotherapist, care or support workers or additional family members.

Does the customer have any other health professional assessments or reports available?
If yes, please attach any relevant reports.

☐ Yes ☐ No

HAVE ANY OF THE FOLLOWING NEEDS BEEN IDENTIFIED

☐ Home Modifications* ☐ Bathroom Modifications* ☐ Kitchen Modifications*

☐ Goods, Equipment and Assistive Technology ☐ Emergency/ Falls Device (Pendant or Watch) ☐ Technology Equipment

☐ Vehicle Modifications ☐ Other: _____

**Please indicate if Homeowner approval is required:* ☐ Yes ☐ No

BILLING/ FUNDING DETAILS

☐ Home Care Package Level 1 ☐ Home Care Package Level 2

☐ Home Care Package Level 3 ☐ Home Care Package Level 4

☐ Self Funded

PERSON OR ORGANISATION RESPONSIBLE FOR INVOICE

Name/ Organisation: _____

Billing Address: _____

Email: _____

Phone: _____ Is a purchase order required? ☐ Yes ☐ No

Please send referral form to enquiries@tadwa.org.au by email
or 371 Collier Road Bassendean 6054 by post.