

OT PROJECT SUMMARY



Job Number:		Date:	
Client Name:		Client Phone:	
Client Address:			
OT Name:		OT Phone:	
OT Email:			

WORK REQUESTED

Safety Concerns & Critical Information

Please identify if applicable:

- | | |
|--|---|
| <input type="checkbox"/> Pets | <input type="checkbox"/> Behavioural Concerns |
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Cognitive Concerns (Encouraged to have family present) |
| <input type="checkbox"/> Hoarding | <input type="checkbox"/> Heavy smoking / smoking in the house |
| <input type="checkbox"/> Squalor & Hygiene | <input type="checkbox"/> Hearing Difficulties |

Is a two-person (TADWA Staff) visit required? Yes No

Financial Hardship

Is the person experiencing financial hardship? Yes No

Would the person like a follow-up phone call regarding financial hardship support? Yes No

Please indicate identifying factors:

- Lives in government housing
- Multiples diagnoses
- Lack of support (isolated/poor networks)
- Poor condition of the house
- Use of incontinence aids
- evidence of inability to fund basic items
- Supporting family experiencing difficulties
- Experiencing increased health issues
- Recently experienced loss through phishing or other fraudulent scam
- Experiencing change in circumstances causing financial hardship
- Client enquires about payment options

Equipment & Assistive Technology

Please Quote

Home Modifications

Building structure

Double Brick

Stud Frame

Other

Please Quote

ALL OTHER THERAPIST RECOMMENDATIONS (EDUCATION / DECLINED)