ACTIVEONE
HEALTH PROFESSIONAL GROUP

REFERRAL TO ACTIVE ONE HEALTH PROFESSIONAL GROUP

Please note: All referrals are screened to ensure we are the right service to support the client's needs. Please ensure ALL sections of the referral form are completed, or we will unfortunately be unable to process the referral.

Requested Services:- **Date of request:-……...**

☐ Occupational Therapy ☐ Exercise Physiology ☐ Dietetics

Is a home visit required? YES ☐ NO ☐

Is a translator required? YES ☐ NO ☐

If yes, which language? ……

Client Information:-

Client Name:-…… D.O.B:-……

Preferred Name (if different to above):……

Gender: Male ☐ Female ☐ Other ☐

Address:-……

Phone/Mobile:-…….. Email:-……..

Next of Kin:-…… Relationship to client:-……...

Phone/Mobile:-…….. Email:-……..

Client's GP:-…… Phone:-……

GP Clinic Name/Address:-……...

Does the client have an appointed legal Guardian? YES ☐ NO ☐

If Yes, Name:-…… Contact:-……..

Referrer's Information:-

Name:-…….. Email:-……..

Relationship to Client:-…….. Phone/Mobile:-……

How did you hear about us?.....

Is the client / NOK aware this referral has been made? YES ☐ NO ☐

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Who should we contact for more information if required?

☑ Client ☐ NOK ☐ Referrer ☐ Other:-……

Who should we contact to book the initial appointment?

☑ Client ☐ NOK ☐ Referrer ☐ Other:-……

Client Details:-

Primary Diagnosis:-

For NDIS participants, ***please list the diagnosis/conditions that are recognised by the NDIS.***

Secondary Diagnoses:-

Any condition that co-exists with the primary diagnosis/condition.

Current Identified Issues/Reason for Referral:-

For Occupational Therapy Referrals ONLY:-

What assessments/ services are being requested?

- ☐ Comprehensive OT Assessment/ Functional Capacity Assessment
- ☐ Accommodation Needs Assessment
- ☐ Support Needs Assessment
- ☐ Home Modifications Assessment
- ☐ Upper Limb Program
- ☐ Neurological Services
- ☐ Aids/Equipment Prescription
- ☐ Driving Assessment
- ☐ Vehicle Modifications Assessment
- ☐ Other

Please provide further details:-

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Are there any risks associated with working with this client and/or the people that they live with, or who may be present during the home visit/consultation?
(e.g.: Aggressive Behaviours, Illicit Drug Use, Excessive Alcohol Use, Unsafe Building/Environment).

YES ☐ NO ☐

If you ticked YES, please provide further information:-

Does this client display Behaviours of Concern or Persistent/Complex Behaviours requiring Specialist Behaviour Support?

YES ☐ NO ☐

If you ticked YES, please provide further information:-

Client Funding Source:-

☐ NDIS:- *Please complete page 4.*

☐ Aged Care/ Home Care Package:- *Please complete page 5, section 1.*

☐ TAC:- *Please complete page 5, section 2.*

☐ Private/ Other:-

Name:-……..

Email:-…… Phone:-……

Postal Address:-……

Once the completed referral form has been received, it will be screened to determine if the requested services can be provided by Active One. Client allocation cannot occur until a clear budget, or approval for the requested services has been provided.

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For NDIS Referrals ONLY:-

NDIS Number:-…… **Current NDIS Plan Expiry date:-** …../…../…..

NDIS Plan Attached YES ☐ NO ☐

NDIS Therapy budget allocation:

Occupational Therapy hours: .....
Exercise Physiology hours: .....
Dietetics hours: .....

Do you intend for the entire Daily Living Budget to be available for Active One Services?

☐ YES ☐ NO

Name of Participant's Representative (if applicable):……..……..

Email:……..……

Postal Address:……

(NB: This person will be responsible for signing all service agreements / service plans on the participant's behalf)

Please tick which payment/funding method applies:

☐ **Plan Managed** – Invoices to be sent to Plan Manager:-……..

Email:-……..…….. Phone:-……..

☐ **Self-Managed** – Invoices to be sent to ……

Email:-……..…….. Phone:-……..

☐ Invoices to the **NDIA direct**

Any additional comments:

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For Aged Care Referrals ONLY:-

Section 1

Home Care Package Level:-

☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4

Case Manager details:- (if not the referrer)

Name:-…… Phone/Mobile:-……..…..

Email:-……

NB: Initial quote must be approved by Case Manager

Invoices to be sent to:-

Name/Addressee:…… Phone:……

Email:……..……

Any additional comments:

For TAC Referrals ONLY:-

Section 2

TAC Claim number:-…….…… **Date of Injury:-**……

Case Manager details:- (if not the referrer)

Name:-……..…… Phone/Mobile:-……..…..

Email:- ……..

NB: Initial quote must be approved by Case Manager

Invoices to be sent to:-

Name/Addressee:…… Phone:……

Email:……..……

Other Key TAC Contact/s:

Any additional comments:

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