

**REFERRAL TO ACTIVE ONE HEALTH PROFESSIONAL GROUP**

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

*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:-.....**

- Occupational Therapy     Exercise Physiology     Podiatry  
 Dietetics     Diabetes Education

Is a home visit required?      YES          NO   

**Client Information:-**

Client Name:-.....      D.O.B:-.....

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:-.....

**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:-**

Medical History/Diagnoses:-

**Current Identified Issues/Reason for Referral:-**

**For Occupational Therapy Referrals ONLY:-**

**What assessments/ services are being requested?**

Comprehensive OT Assessment/ Functional Capacity Assessment	<input type="checkbox"/>	Neurological Services	<input type="checkbox"/>
Accommodation Needs Assessment	<input type="checkbox"/>	Aids/Equipment Prescription	<input type="checkbox"/>
Support Needs Assessment	<input type="checkbox"/>	Driving Assessment	<input type="checkbox"/>
Home Modifications Assessment	<input type="checkbox"/>	Vehicle Modifications Assessment	<input type="checkbox"/>
Upper Limb Program	<input type="checkbox"/>	Other	<input type="checkbox"/>

**Please provide further details:-**

**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:-**

- Self/Private       NDIS       Aged Care  
 Other (Please specify).....

Who should we direct the invoice/s to?.....

Postal Address:-.....

Email:-.....

**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 for the requested services has been provided.**

**For NDIS Referrals ONLY:-**

NDIS Plan Attached    YES     NO

**NDIS Therapy budget allocation:**

Occupational Therapy hours:                    .....

Exercise Physiology hours:                    .....

Podiatry hours:                    .....

Dietetics hours:                    .....

Diabetes Education hours:                    .....

Do you intend for the entire Daily Living Budget to be available for Active One Services?  
 YES     NO

**NDIS Number:-**..... **Current NDIS Plan Expiry date:-** ..../..../20...

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

Email:.....

Postal Address:.....

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

**Please tick which payment/funding method applies:**

- Invoices to the **NDIA direct**
- Self-Managed** – Invoices to be sent to:  
Name:-..... Email:-.....
- Plan Managed** – Invoices to be sent to:  
Plan Manager:-..... Email:-.....

Any additional comments:

**PLEASE FAX OR EMAIL YOUR REFERRAL TO THE ACTIVE ONE OFFICE:  
Fax: (03) 87070778 OR Email: [info@activeonegroup.com](mailto:info@activeonegroup.com)**