

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:-.....

- | | | |
|---|--|--|
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Exercise Physiology | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Dietetics | <input type="checkbox"/> Diabetes Education | <input type="checkbox"/> Wound Service |

Is a home visit required? YES NO

Client Information:-

Client Name:-..... D.O.B:-.....

Gender: Male Female

Address:-.....

Phone/Mobile:-..... Email:-.....

Next of Kin:-.....

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:-.....

Referrers 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?

Functional Needs Assessment	<input type="checkbox"/>	Accommodation Needs Assessment	<input type="checkbox"/>
Aids/Equipment Prescription	<input type="checkbox"/>	Driving Assessment	<input type="checkbox"/>
Home Modifications Assessment	<input type="checkbox"/>	Mobility/Transportation Assessment	<input type="checkbox"/>
Wheelchair/Scooter Assessment	<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 TAC Aged Care
 Other (Please specify).....

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

Postal Address:-.....

Email:-.....

For NDIS clients ONLY:-

NDIS Plan Attached? YES NO

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

Participant's Representative:-.....

(Please note: if you choose to list a representative above, this person will be responsible for signing all service agreements / service plans on the participants behalf)

Please tick which payment/funding method applies:

Please send all invoices to the **NDIA direct**

Self-Managed – We request invoices to be sent to:

Name:-..... Email:-.....

Plan Managed – We request invoices to be sent to the plan management provider below:

Plan manager/Organisation name:-.....

Phone:-..... Email:-.....

Postal Address:-.....

Are there **other** service providers sharing the Improved Daily Living Skills Budget?

YES NO

If no, do you intend the entire Improved Daily Living Skills Budget to be available for Active One Services?

YES NO

Any additional comments regarding funding / budget :-

Once the completed referral form has been received, it will be screened to determine that the requested services can be provided by Active One Group.

PLEASE FAX OR EMAIL YOUR REFERRAL TO THE ACTIVE ONE OFFICE

Fax: (03) 87070778

OR

Email: info@activeonegroup.com