**GENERAL REFERRAL Form – Lime Occupational Therapy**

PART A – PARTICIPANT INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Mr /Mrs / Miss / Ms / Dr** |  | **Date of Birth** |  |
| **First / Given Name(s)** |  | **Last / Family Name** |  |
| **Phone Number** |  | **Mobile Number** |  |
| **Translator Required** | [ ]  Yes [ ]  No Language: |
| **Email** |  |
| **Residential Address** |  |
| **Postal Address** |  |
| **Private Health?** | [ ]  Yes [ ]  No  | **DVA Card Number** |  |
| **Insurer** |  | **Claim Number** |  |

PART B – PARENT / CARER INFORMATION Client gives permission to contact? [ ]  Y [ ]  N

|  |  |
| --- | --- |
| **Relationship to Client** |  |
| **Mr /Mrs / Miss / Ms / Dr** |  |  |  |
| **First / Given Name(s)** |  | **Last / Family Name** |  |
| **Phone Number** |  | **Email** |  |

PART C – CASE MANAGER / COORDINATOR / OTHER Client gives permission to contact? [ ]  Y [ ]  N

|  |  |
| --- | --- |
| **Relationship to Client** |  |
| **Mr /Mrs / Miss / Ms / Dr** |  |  |  |
| **First / Given Name(s)** |  | **Last / Family Name** |  |
| **Phone Number** |  | **Email** |  |
| **Organisation / School** |  |

PART D – DETAILS OF REFERRAL

**Referral Type**

|  |  |
| --- | --- |
| [ ]  | Occupational Therapy |

**Reason for Referral / Referral Request (What would you like us to do?)**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | NDIS Access / Pre-Planning Assessment  | [ ]  | Capacity Building / Rehabilitation |
| [ ]  | Initial Assessment  | [ ]  | Sensory Profile |
| [ ]  | Functional (ADL) Assessment | [ ]  | Cognitive Screen  |
| [ ]  | Recreation / Work Services | [ ]  | Housing Assessment |
| [ ]  | Home Modifications *(note modifications required)*[ ]  Access / Ramps [ ]  Bathroom [ ]  Kitchen [ ]  Other |
| [ ]  | Equipment Prescription (Assistive Technology) *(note equipment required if known)*[ ]  Manual / Powered Wheelchair [ ]  Electric Scooter [ ]  Mobility aid [ ]  Hoists [ ]  Commode[ ]  Pressure Care Equipment [ ]  Recliner Chairs [ ]  Electric Bed [ ]  Rails [ ]  Bidet [ ]  Alternative & Augmentative Communication (AAC) [ ]  Other  |
| [ ]  | Other |

**Information about your Disability / Diagnosis / Past Medical History** *(please provide as much detail as possible to assist us in triaging your referral and ensuring the therapist allocated is appropriate for the client and their needs)* Copy of Past Medical History attached [ ]  Yes [ ]  No

**Additional Comments**

Additional information attached [ ]  Yes [ ]  No

PART E – GP DETAILS OF THE PERSON REQUIRING SUPPORT

|  |  |
| --- | --- |
| **Is this information important?** | *We recognize the health and disability needs and supports of each individual. A GP is an important member of a person’s care team and we may need to communicate with the GP practice in order to meet the needs of our clients.* |
| **GP Name** |  |
| **Practice Name / Address** |  |

PART G – DETAILS OF THE PERSON COMPLETING THIS FORM

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Organisation** |  |
| **Phone** |  | **Fax** |  |
| **Email** |  | **Date of Referral** |  |

WHAT HAPPENS NEXT?

Please send this completed form to admin@lime-therapy.com.au or FAX 1300 686 768.

For any additional information or assistance with completing the form please contact the friendly team at Lime Therapy on 1300 418 978.

Upon receipt of your referral the information provided will be used to triage the participant to one of our therapists, one of our team will then make contact to set up your initial appointment.