Occupational Therapy Referral

Extend Occupational Therapy

Please return this form via email to: extend.occupationaltherapy@gmail.com

If you wish to discuss referrals, please call : 0400 229 616

Referral	
Date submitted	
Date processed (admin use only)	

Patient Details	
Patient's Name	
Date of Birth	
Address	
Best contact number(s)	

General Practitioner Details	
G.P. Name	
G.P. Name of Practice	
G.P. Phone	
G.P Fax	
G.P Provider Number	

Health Fund Details		
Private Health Fund ☐	Provider:	
Medicare ☐		
DVA ☐	Number:	Gold ☐ White ☐

Reason for referral			
Functional assessment/Education	☐	Pre-Discharge Home Assessment	☐
Post-Discharge Home Assessment	☐	Home Rehabilitation Program	☐
Palliative Care	☐	Equipment/Home Modifications	☐

Living/social situation		Accomodation	
Lives alone	☐	Private	☐
Lives with spouse	☐	Rented	☐
Family/Friends	☐	Homes West	☐

Next of Kin	
Name	
Contact Number	
Preferred person to contact	Patient ☐ Next of Kin ☐

Patient's Function	
Mobility	
Self Care	
Cognition	
Comments	

Referred By			
Name			
Position			
Provider Number		Contact Number	
Place of work		Signature	

Discharge Details (if patient is currently an in patient)		
Date		
Discharge Summary Attached	Yes ☐	No ☐
Safety Concerns		