

PARTICIPANT DETAILS			
Name:		Date of Birth:	
Address:			
Phone:			
Other Contact Person:			
Phone:		Relationship:	
NDIS Participant Number:			
NDIS Plan dates:		NDIS Funding: ☐ Self managed ☐ NDIA managed ☐ Plan managed	Plan Manager: Company: Contact Person: Email:
Primary Diagnosis/ Disability:			
Relevant other medical and social history:			

REFERRER/ SUPPORT COORDINATOR DETAILS			
Name:		Referral Date:	
Contact number:		Email:	
Organisation/ Address- if relevant			
Reason for Referral:	☐ Physiotherapy ☐ Speech Pathology ☐ Exercise Physiology ☐ Podiatry ☐ Dietitian ☐ Occupational Therapy ☐ Functional Assessment ☐ OT Therapy - Improved Daily Living ☐ Emotional regulation and socialisation capacity building ☐ Sensory processing strategies ☐ Self-care / daily living skills (toileting, showering, brushing teeth, dressing, grooming, community access and budgeting). ☐ Fine and gross motor skills ☐ Mental health capacity building ☐ Stroke and neurological rehabilitation ☐ Cognitive assessment and retraining ☐ Pressure injury prevention, education and intervention ☐ Other:		

Reason for Referral:	☐ Home Modifications (please tick): ☐ Minor ☐ Major
	☐ Assistive Technology: ☐ Low cost assistive technology (shower chairs, 4WW, toilet frames, etc). ☐ Manual wheelchair ☐ Power wheelchair ☐ Mobility scooter ☐ Adjustable bed ☐ Electric lift chair ☐ Other:

DOCTOR DETAILS	
Doctor's name:	
Clinic name:	
Phone:	

ADDITIONAL REPORTS/ INFORMATION TO HELP ASSIGN A SUITABLE THERAPIST (Sent as an ATTACHMENT)				
Health Summary	Yes	☐	No	☐
Specialist Reports	Yes	☐	No	☐
NDIS Plan	Yes	☐	No	☐

REPORT DETAILS	
Consent to request reports:	☐ Yes ☐ No
Request return report:	☐ Yes ☐ No
Report to be sent to: (name and email)	

SAFETY / ACCESS INFORMATION	
Is there adequate parking available?	☐ Yes ☐ No
Are animals restrained?	☐ N/A ☐ Yes ☐ No
Is there mobile phone coverage?	☐ Yes ☐ No
Does anyone smoke in the home?	☐ N/A ☐ Yes ☐ No
Are there any other safety of access issues to be aware of? (eg: firearms/ history of illicit drug & alcohol dependence/ isolated area)	☐ No ☐ Yes – Please provide details:

Please return completed form to: refer@opthealth.com.au or fax 02 8004 8133

For Optimum Administration Only		
☐ Follow up required	☐ Entered into Front Desk	☐ Emailed Occupational Therapist
☐ NDIS service agreement sent/ received??	☐ Referral accepted	☐ Referral declined Reason: