Occupational Therapy Services Group

Home

Date of Referral: __/__/__

Patients Name:	**Private health fund:**
Address:	**D.O.B:**
	DVA Entitled card holder details: ☐ White Card ☐ Gold Card
Tel No:	**Contact person/ No. :**
Presenting Diagnosis/problems: **PMHx:**	**Reason for referral:** ☐ Home assessment ☐ Palliative care ☐ Home rehabilitation program ☐ Post operative ☐ Homefront Safety Pro ☐ Falls prevention ☐ Other: _____
Weight: **Heel – popliteal:**	**Falls Risk:** ☐ Yes ☐ No No. of falls /12 months
Social situation: ☐ Alone ☐ Spouse ☐ Family/friends **Accommodation:** ☐ Private ☐ Rented ☐ Homes West	**Care services:** ☐ Nursing ☐ Domestic ☐ None **Social supports:** ☐ Spouse _____ ☐ Family/friends _____ ☐ None
Current function **Transfers:** **Shower** ☐ Independent ☐ Sit to shower ☐ Commode ☐ Assisted ☐ H/shower ☐ Other ___ ☐ Dependent ☐ Rails _____ **Bed** ☐ Independent ☐ Bedrail ☐ Other ___ ☐ Assisted ☐ O/bed pole _____ ☐ Dependent **Chair** ☐ Independent ☐ Height adj chair ☐ Other ___ ☐ Assisted ☐ Electric recline _____ ☐ Dependent	**Transfers (cont):** **Toilet** ☐ Independent ☐ OTF/raiser ☐ Continent ☐ Assisted ☐ Commode ☐ Incontinent ☐ Dependent ☐ Urinal ☐ Catheter ☐ Rails ☐ Colostomy **Ambulation** ☐ Independent ☐ W/stick ☐ Seat walker ☐ Assisted ☐ Crutches ☐ W/C _____ ☐ Dependent ☐ W/frame ☐ Full wt bear **IADLS** **Meal prep** **Medication Mgmt** **Transport** ☐ Independent ☐ Independent ☐ Independent ☐ Assisted ☐ Assisted ☐ Assisted
Referring practitioner: **Provider number:** **(if applicable)** **Contact details:** ☐ Report required	**Assessment required:** ☐ Pre discharge ☐ Post discharge **Date of Discharge:** ☐ Client is aware of cost (if applicable)
	Precautions Medical: Behavioural: 2-person visit required: ☐ Yes ☐ No