OCCUPATIONAL
THERAPY SERVICES GROUP

Find out more:
(08) 9332 1783
info@otservicesgroup.com
www.otservicesgroup.com

Referral Form

☐ Urgent Assessment

CLIENT DETAILS:

Name: _____ DOB: _____

Address: _____

Preferred Contact Number: _____ ☐ Pensioner

Next of kin: _____ Relationship: _____

Contact Number: _____

MEDICAL HISTORY:

Diagnosis: _____ Date of Onset: _____

Service Required: ☐ DRIVING ☐ SKILL BUILDING ☐ HOME
☐ ASSISTIVE TECHNOLOGY ☐ CONSULTANCY

Medical History: ☐ Attached _____

Impairments / Functional Limitations: _____

Medication/s: ☐ Attached _____

REFERRER DETAILS:

Name: _____

Prov No: _____

Profession: _____

Address: _____

Telephone: _____ Fax: _____

Signed: _____

TREATING DOCTOR DETAILS: (If different from referrer)

Name: _____

Prov No: _____

Speciality: _____

Address: _____

Telephone: _____ Fax: _____

Signed: _____

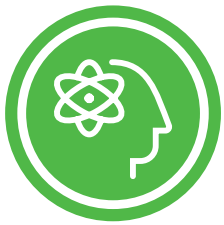
Please Note: When referring for an Occupational Therapy Driving Assessment we assume that medical clearance to drive is provided to undertake the assessment and also permission is given to release the referral information to the Department of Transport.

ACCOUNT DETAILS: (Please Tick)

- ☐ Insurance / WorkCover
- ☐ Employer
- ☐ Medicare Enhanced Primary Care (EPC)
- ☐ Disability Equipment Grant (DEG)
- ☐ NDIS
- ☐ Home Care Package
- ☐ Veteran Affairs (DVA) White / Gold
- ☐ Private Health Fund
- ☐ Insurance Commission (ICWA)
- ☐ JOBACCESS
- ☐ Other _____

Once completed please Fax referral form to **(08) 9332 6548** OR Email referral to **referrals@otservicesgroup.com**
Alternatively post a hard copy to: **2 Gracechurch Crescent, Leeming WA 6149**

DRIVING



SKILL BUILDING

HOME

ASSISTIVE TECHNOLOGY

CONSULTANCY

ABN 33 827 987 190