



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)

- | | |
|---|---|
| <input type="checkbox"/> Insurance / WorkCover | <input type="checkbox"/> Veteran Affairs (DVA) White / Gold |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Private Health Fund |
| <input type="checkbox"/> Medicare Enhanced Primary Care (EPC) | <input type="checkbox"/> Insurance Commission (ICWA) |
| <input type="checkbox"/> Disability Equipment Grant (DEG) | <input type="checkbox"/> JOBACCESS |
| <input type="checkbox"/> NDIS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Home Care Package | |



DRIVING



SKILL BUILDING



HOME



ASSISTIVE TECHNOLOGY



CONSULTANCY

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