Client Referral Form

Area:

- Geelong/ West Melbourne Sessions
- Available for Telehealth sessions anywhere in Victoria

* Indicates required question

1. Email *

Occupational Therapy Services

2. Full Client Name: *

3. Client DOB: *

4. Client Address (please include postcode): *

5. Parent/Guardian name (If applicable):

6. Primary Email to contact:

7. Primary Phone Number: *

8. Support Co-ordinator (SC) for NDIS participants:

Check all that apply.

- [ ] Yes SC involved
- [ ] No but has SC funding within NDIS plan
- [ ] No SC involved

9. Funding Type: *

Check all that apply.

- [ ] Privately funded
- [ ] NDIS funded
- [ ] Medicare funded
- [ ] Private while waiting for NDIS Plan - already pre-approved
- [ ] Other:

10. NDIS Participants: How is the funding managed?

Check all that apply.

- [ ] Self-Managed
- [ ] Plan-Managed - Please write email to send invoices in "other"
- [ ] NDIS Managed
- [ ] Other: _____

11. NDIS number if NDIS funded:

_____

12. OT Sessions: *

Check all that apply.

- [ ] Ongoing Therapy Sessions
- [ ] Assessments
- [ ] Therapy Plan
- [ ] Functional Capacity Report
- [ ] NDIS Review/ Change of Circumstances Report
- [ ] NDIS application report
- [ ] Home Modifications/Equipment
- [ ] Other: _____

13. Frequency: *

Check all that apply.

- [ ] Weekly
- [ ] Fortnightly
- [ ] Monthly
- [ ] Temporarily to help get onto NDIS
- [ ] When needed

14. Location of therapy: *

We are a community service and do not offer an office space.

Check all that apply.

- [ ] Client Home (after school slots are not currently available)
- [ ] In community (coffee shop, SC office)
- [ ] Education (school, childcare)
- [ ] Telehealth
- [ ] Mix of locations
- [ ] Other: _____

15. Waitlist:

Would you like to go on a waitlist for a late afternoon/ after school slot?

Check all that apply.

- [ ] Yes
- [ ] No
- [ ] Yes and try to organise school/day slots in the meantime

16. **For School sessions**:

What school do they attend? Please include the campus location.

Please ensure the school allows therapy sessions onsite.
Please provide bell-times and available session slots based on class subjects.
Our OT's availability will depend on this information for school sessions.

_____

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_____

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_____

17. Diagnosis:

Check all that apply.

- [ ] Autism (ASD)
- [ ] ADHD
- [ ] ODD
- [ ] OCD
- [ ] Sensory Processing Disorder
- [ ] Speech difficulties
- [ ] Mental health difficulties
- [ ] Cognitive difficulties (learning disorder, cognitive disorder, low IQ)
- [ ] Undiagnosed
- [ ] Other: _____

18. Please use this opportunity to provide further details about client presentation or email turnertherapygeelong@gmail.com reports you may have.

_____

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19. Do you consent for our Occupational Therapists to discuss the information provided on this form with other health professionals involved with the client? (Speech Therapist, Psychologist, Behaviour Support Therapist)

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Other: _____

20. **NDIS Participants**

Amount of OT/ therapy funding able to allocate:

_____

21. Would you be interested in a social interaction and skill development program held on the weekend monthly by our OT?

Check all that apply.

- [ ] Yes client would be interested
- [ ] Saturday Morning works well
- [ ] Saturday afternoon works well
- [ ] Sunday morning works well
- [ ] Sunday afternoon works well
- [ ] No we are not interested

Our process is to email you to clarify information to determine our Occupational Therapists availability.
We complete a quote of what our services would look like in additional to our Service Agreement- both need to be signed prior to commencing sessions.

Our prices align with the NDIS pricing guidelines of $193.99 per hour + notes and travel.

Please note all information provided on this referral form is confidential between TurnerTherapy Services, unless consented otherwise.

Thank you for completing this referral.
We will contact you as soon as we can.