Level 1/291 The Parade
Beulah Park SA 5067
T: 08 8331 0566
F: 08 8331 0277
E: admin@livingtothemax.com.au
W: livingtothemax.com.au
ABN: 32 141 219 785

We are now part of Ability Action Australia

Occupational Therapy Referral

PART A

Client Name:	
Client DOB:	
Client Address:	
Client Telephone:	
Client Email:	
Name of legal guardian (if applicable):	
Phone of legal guardian (if applicable):	
Email of legal guardian (if applicable):	
Name and relationship of emergency contact:	
Phone of emergency contact:	
Email of emergency contact:	
Name of General Practitioner (if applicable):	
Clinic where GP practices (if applicable):	
DVA Number (if applicable):	
RTWSA/Workcover Claim Number (if applicable):	
Do you have a Case Manager/Service Planner?	Yes/No (please circle one) If yes, please provide contact details below.
Name of Case Manager/Service Planner:	
Agency of Case Manager/Service Planner:	
Phone of Case Manager/Service Planner:	

Email of Case Manager/Service Planner:	
Are you on a My Aged Care Homecare package?	Yes/No (please circle one) If yes, please provide details below. If no, please refer to Part B.
If you are a My Aged Care recipient, do you have a third-party provider who administers your homecare package?	Yes/No (please circle one) If Yes, please provide contact details of the provider who administers your package below.
Agency/Provider:	
Phone number:	
Email address:	
Is the agency/provider aware of this referral?	Yes/No (please circle one)

PART B

Information about your diagnosis, disability and/or medical condition/s (please provide as much detail as possible and attach additional information if required.)

Living to the Max OCCUPATIONAL THERAPY | Ability Action AUSTRALIA

We are now part of Ability Action Australia

Referral request (what would you like us to do?)	
Is this a Self-Referral:	Yes/No (please circle one) If no, please complete referrer information below
Referrer name:	
Referrer organisation:	
Referrer phone number:	
Referrer email:	
Who is the best person to contact about this referral?	
Date this form is being completed:	

NOTE: Please complete the client risk assessment form below before returning

Living to the Max OCCUPATIONAL THERAPY | Ability Action AUSTRALIA

We are now part of Ability Action Australia

CLIENT RISK ASSESSMENT FORM	
Client name: **Guardian name (if applicable)** **Emergency contact name:**	**Date of risk assessment (pre-home visit)**:

PRE-HOME VISIT

SECTION A: HIGH RISK BEHAVIOURS	**YES**	**NO**
1. Does anyone else need to be present at the appointment? If so, who?	☐	☐
2. Are there any current concerns in relation to substance abuse?	☐	☐
3. Is there any risk of physical aggression? If so, please specify:	☐	☐
4. Are there any behaviours of concern? If so, please specify:	☐	☐
5. Does the client smoke? If so, please refrain from smoking indoors for the duration of the home visit	☐	☐
SECTION B: RISKS ASSOCIATED WITH HOME VISITS	**YES**	**NO**
1. Are there aggressive animals present? Please ensure they are secured.	☐	☐
2. Are there concerns regarding accommodation or household issues (ie weapons/firearms, clutter, absence of working fire alarms)? If so, please specify:	☐	☐
3. Is it likely that other people will be present at your home (ie, family, friends, carer, other residents)? If so, please specify:	☐	☐
4. Of those who may be present, are there any behaviours of concern? If so, please specify:	☐	☐
5. Does the client have an infectious disease? If so, please specify:	☐	☐
Additional comments (pre and/or post initial assessment)		