Living to the Max OCCUPATIONAL THERAPY | Ability Action AUSTRALIA

We are now part of Ability Action Australia

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Occupational Therapy Referral – NDIS

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):	
NDIS Number:	
NDIS plan expiry date:	
Do you have a Support Coordinator? *NOTE: A Support Coordinator is a 3rd party provider engaged to assist you in identifying and sourcing supports.*	Yes/No (please circle one) If yes, please provide contact details below.
Name of Support Coordinator:	
Phone number of Support Coordinator:	
Email address of Support Coordinator:	

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How is your NDIS funding managed?	▫ Self-managed ▫ Agency (NDIA) managed ▫ Plan Manager (advise below)
Name of Plan Manager (if applicable):	
Phone number of Plan Manager (if applicable):	
Email address of Plan Manager (if applicable):	
Information about your disability and/or other medical conditions (please provide as much detail as possible and attach additional information if required.)	

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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:	
Date you are completing this form:	

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

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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)		