Occupational Therapy

ADULT REFERRAL FORM

Date: _____

Personal Details

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Suburb: _____ Postcode: _____

Preferred Contact Person: _____

Phone: _____

Email: _____

Carer Name *(if applicable)*: _____

Phone: _____

Email: _____

Language/s spoken at home: _____ Interpreter Required: ☐ Yes ☐ No

Referral Details

Does the person have: ☐ Medicare Enhanced Primary Care Plan or Team Care Arrangement

☐ Private Health Insurance

NDIS Details

Does the person have an NDIS Plan: ☐ Yes ***(Please include the NDIS Plan to assist with processing of the referral)***

☐ No

How is the NDIS Plan Managed:

☐ **Self-managed**

Person responsible for payment: _____

Phone: _____ Email: _____

Are you able to pay upfront? ☐ Yes ☐ No

☐ **Plan Managed**

Business Name: _____ Contact Name: _____

Phone: _____ Email: _____

☐ **Agency Managed**

☐ **Support Coordinator**

Support Coordinator Name: _____

Phone: _____ Email: _____

General Practitioner

General Practitioner Name: _____

GP Practice: _____

Do you give consent for us to liaise with the GP if necessary: ☐ Yes ☐ No

Please continue to next page

Reason for Referral and Other Information

Please describe concerns *(e.g. functional difficulties, goals, concerns, strengths)*:

Relevant Medical History *(e.g. medication, current and previous diagnosis)*:

Other service providers involved, including previous therapy *(please provide name)*:

Any additional information that you feel is relevant to this referral:

Referrer Information

Name: _____ Phone: _____

Role: _____

Please return this completed form, a copy of the NDIS plan and any other relevant documentation to Amity Health via one of the following methods:

Email: query@amityhealth.com.au

Fax: 9842 2798

Amity Health will contact you as soon as possible to discuss your referral.
For more information please visit our website www.amityhealth.com.au or contact Amity Health on 9842 2797