REFERRAL FORM

DUBBO REGIONAL OT

Client Details:

Client Name	
Date of Birth	
Address	
Phone	
Mobile	
Email	
Alternative Contact	

Referral Details:

Date:	
Referred By:	
Contact Number:	
Organisation:	
Email:	

Funding Body

☐ Care Package *please specify, e.g: HCP L2, TACP, STRC*	☐ Lifetime Care and Support	☐ Self funding	☐ Other (*please specify)*:
☐ NDIS (*Please complete below)*			
Participant Number:		Plan End Date:	
☐ Plan Managed *(please complete the below)*		☐ Self funding	☐ NDIA Managed
Plan Manager:	Name:	Email:	Phone:
Support Coordinator	Name:	Email:	Phone:
Approximate hours of OT required:		OT financial allocation in NDIS Plan:	$

Diagnosis/Medical Condition

Presenting Problems

Intervention Requested

☐ Driving Assessment Licence Number: Auto/Manual: Date required by: Medical complete: ☐ Yes ☐ No	☐ Wheelchair Script ☐ Manual ☐ Power Current chair:	☐ Home Modifications ☐ Rails ☐ Ramp ☐ Bathroom ☐ Kitchen
☐ Other Equipment	☐ ADL assessment ☐ ADL retraining	☐ Home Safety Assessment
☐ Cognitive Assessment	☐ Upper Limb Assessment ☐ Upper Limb Therapy	☐ Other:

Please return to admin@drot.com.au