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| **CLIENT DETAILS** |
| **Date of Referral:** |  | **Client Name:** |  |
| **Date of Birth:** |  | **Sex:** | [ ] Male [ ] Female [ ] Other |
| **Does the client speak English:** | ☐Yes ☐No If no, please comment: |
| **Address:** |  |
| **Contact Number(s):** |  |
| **NEXT OF KIN DETAILS**  |
| **NOK Name and relation:** |  | **Contact Number(s):** |  |
| **FUNDING DETAILS** |
| **HCP** | [ ] Yes [ ] No  | **HCP level** | [ ]  1 [ ]  2 [ ] 3 [ ] 4  |
| **Medicare****CDM/EPC** | [ ] Yes [ ] No  | **GPMP attached** |  [ ]  Yes [ ] No  |
| **DVA** | [ ] Yes [ ]  No  | **DVA card number** | Type: [ ] White [ ] Gold |
| **NDIS** | [ ] Yes Number:Plan Review Date: | **Private payment** |  [ ] Yes [ ] No  |
| **REFERRER DETAILS**  |
| **Referral Type:** | [ ] Home Care Provider [ ] Aged Care Facility [ ] Private [ ] GP [ ] NDIS [ ]  Other: |
| **Organisation Name:** |  |
| **Address:** |  |
| **Referrer Name:** |  | **Position:** |  |
| **Contact Number:** |  | **Fax Number:** |  |
| **Email Address:** |  |
| **NDIS INVOICING DETAILS** **(if client is self managed or plan managed by another organisation, please provide details)** |
|  [ ]   **Plan Managed**  [ ]  **Self-Managed**  [ ]  **NDIA**  |
| **Organisation name (if plan managed** |  | **Contact Name** |  |
| **Contact Number** |  | **Email Address** |  |
| **GENERAL PRACTITIONER DETAILS** |
| **GP Name:** |  | **Clinic Name:** |  |
| **Contact Number:** |  | **Fax Number:** |  |
| **Email Address:** |  |

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| **REFERRAL DETAILS**  |
| **Reason for Referral:** ***The more information you can provide, the better the service we can deliver!***Please include details such as:* Diagnosis
* Recent hospital admissions
* Event(s) triggering the referral
* Key dates
* Attach supporting documentation if available (allied health hospital discharge summaries, doctor’s letters etc)
 |  |
| **Past medical history:** |  |
| **Additional notes or further information:** |  |
| [ ]  **PHYSIOTHERAPY (PT)** |
| **Anticipated intervention(s) required (PT):**If unsure, please do not hesitate to ask us or simply select ‘unsure’. | [ ] Virtual Physiotherapy[ ] Mobility Ax [ ] Falls Ax [ ] Exercise Program [ ] Manual Handling Training [ ] Respiratory Treatment [ ] Injury Management  | [ ] Massage Therapy[ ] Pain Management [ ] Post Hosp/Operative care[ ] NDIS Report[ ] Unsure[ ] Other *(please specify):* |
| **Anticipated frequency (PT):**(pending clinician’s assessment and recommendations) | [ ] Daily [ ] Twice weekly [ ]  Weekly [ ] Fortnightly [ ] Monthly [ ] Once off [ ] Unsure [ ] Other *(please specify)*: |
| **Anticipated duration (PT):**(pending clinician’s assessment and recommendations) | [ ]  Ongoing until specified date (often the program review date):[ ]  Number of weeks: [ ]  Number of months:[ ] Once off assessment [ ] Unsure |
| [ ]  **OCCUPATIONAL THERAPY (OT)** |
| **Anticipated intervention(s) required (OT):**If unsure, please do not hesitate to ask us or simply select ‘unsure’. | [ ] Ongoing OT treatment [ ] Home Safety Ax [ ] Mobility/Transfer Ax[ ] Fall Prevention [ ] Daily Living Ax[ ] Minor Home Modifications [ ] Major Home Modifications[ ] Pressure Care Ax | [ ] Manual Wheelchair Prescription[ ] Power Wheelchair Prescription[ ] Personal Alarm [ ] Equipment Prescription[ ] NDIS Report [ ] Unsure [ ]  Other, *(please detail):*  |
| **Anticipated program frequency (OT):**(pending clinician’s assessment and recommendations) | [ ] Once off assessment [ ] Monthly [ ] Fortnightly [ ] Weekly [ ] Twice weekly [ ] Daily [ ] Unsure |
| **Anticipated duration (OT):**(pending clinician’s assessment and recommendations) | [ ]  Ongoing until specified date (often the program review date):[ ]  Number of weeks: [ ]  Number of months:[ ] Once off assessment [ ] Unsure |

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| **HOME VISIT SAFETY AND ACCESS CHECKLIST** |
| **Type of Residence:** | [ ] House [ ] Independent living[ ] Aged Care Facility [ ] Apartment/Flat[ ] Other (please comment): |
| **Client Risk Factors:** | [ ] Aggression [ ] Behavioural Issues[ ] Alcohol/Drug Abuse [ ] Cognitive Issues[ ] Mental disorder [ ] Familial issues[ ] Criminal history [ ] Other (please comment):*If yes to any, please detail:*  |
| **CONSENT TO REFERRAL** |
| I have obtained from the client, NOK or guardian, consent to provide the clients personal information to Ignite Healthcare for further assessment. |
| **Signature/Print name:** |  | **Date:** |  |

Please provide **as much information as possible** to assist with the referral process and send to info@ignitehealthcare.com.au