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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](mailto:info@ignitehealthcare.com.au)