



## Occupational Therapy Referral Form

Please note: We are a regional private practice with a limited capacity for the patients in which we can engage. Due to the considerably broad nature of Occupational Therapy, and range of disabilities, we can only offer services within our scope of practice and expertise, as well as those to which the facilities and resources available to us allow. Our capacity to engage new patients will be accepted on a case by case basis. Referrals received will be reviewed by our therapists to determine if we are best placed to support the patient. If deemed appropriate for our practice the patient will be contacted and offered an appointment..

### Client Details

<b>Client Name:</b>	
<b>Client Date of Birth:</b>	
<b>Gender:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Unspecified
<b>Client Residential Address:</b>	Address:  Suburb: <span style="float: right;">Postcode:</span>
<b>Contact Mobile:</b>	
<b>Contact Email:</b>	

## Referrer Details

Person filling out referral form (if not client):	
Contact Mobile:	
Contact Email:	
Relationship to client:	

## Funding

Funding/rebate source:	<input type="checkbox"/> Private <input type="checkbox"/> NDIS <input type="checkbox"/> GP referral (Medicare) <input type="checkbox"/> DVA <input type="checkbox"/> Home Care Package
General Practitioner (GP):	GP Name:  GP Practice:  Consent to contact: <input type="checkbox"/> Yes <input type="checkbox"/> No

## National Disability Insurance Scheme (NDIS)

NDIS Plan Number:	
NDIS Plan Expiry Date:	
Is your plan:	<input type="checkbox"/> Self managed <input type="checkbox"/> Plan managed <input type="checkbox"/> Agency (NDIA) managed

Local Area Coordinator (LAC):	
Support Coordinator (if applicable):	Name: Company: Email: Mobile:
Plan Manager (if applicable):	Name: Company: Email: Mobile:

## Reason for Referral

Client Diagnosis (if applicable):	
Primary concerns (e.g, functional difficulties, goals, barriers, strengths):	
Reason for referral (e.g, ongoing therapy, assessment, NDIS reporting, NDIS access, etc.):	

Other service providers (e.g, physiotherapist, speech pathologist, specialists, psychologist etc.):	
Areas of concern (tick applicable):	<input type="checkbox"/> Mobility <input type="checkbox"/> Equipment needs <input type="checkbox"/> Home modifications <input type="checkbox"/> Self-care <input type="checkbox"/> Fine motor skills <input type="checkbox"/> Gross motor skills <input type="checkbox"/> Sensory processing <input type="checkbox"/> Emotional regulation <input type="checkbox"/> Fatigue <input type="checkbox"/> Attention/concentration <input type="checkbox"/> Social/play skills <input type="checkbox"/> Mental Health
Other additional information:	

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**Please return this referral and any other relevant documentation (NDIS plan, allied health reports) to: [admin@oceanbeachphysio.com.au](mailto:admin@oceanbeachphysio.com.au)**

Our administration staff at Ocean Beach Physio and Allied Health will contact you as soon as possible to discuss your referral.

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