ACTIVEONE
HEALTH PROFESSIONAL GROUP

REFERRAL TO ACTIVE ONE HEALTH PROFESSIONAL GROUP

How did you hear about us?..

Please note: All referrals are screened to ensure we are the right service to support the client's needs. Please ensure ALL sections of the referral form are completed, or we will unfortunately be unable to process the referral.

Requested Services:- **Date:-……………...**

☐ Occupational Therapy ☐ Exercise Physiology ☐ Podiatry
☐ Dietetics ☐ Diabetes Education (NDIS unavailable)

Is a home visit required? YES ☐ NO ☐

Client Information:-

Client Name:-…………………………………………………… D.O.B:-………………

Gender: Male ☐ Female ☐ Other ☐

Address:-……………………………………………………………………………………

Phone/Mobile:-……………………….. Email:-……………………………………..

Next of Kin:-……………………………… Relationship to client:-…………………..

Phone/Mobile:-……………………….. Email:-……………………………………..

Client's GP:-……………………………… Phone:-……………………………………

GP Clinic Name/Address:-……………………………………………………………...

Does the client have an appointed legal Guardian? YES ☐ NO ☐

If Yes, Name:-…………………………… Contact:-…………………………………..

Referrer's Information:-

Name:-…………………………………….. Email:-……………………………………..

Relationship to Client:-………………….. Phone/Mobile:-……………………………

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Who should we contact for more information if required?

☐ Client ☐ NOK ☐ Referrer ☐ Other:-…………………………..

Who should we contact to book the initial appointment?

☐ Client ☐ NOK ☐ Referrer ☐ Other:-…………………………..

Client Details:-

Medical History/Diagnoses:-

Current Identified Issues/Reason for Referral:-

For Occupational Therapy Referrals ONLY:-

What assessments/ services are being requested?

Comprehensive OT Assessment/ Functional Capacity Assessment ☐
Accommodation Needs Assessment ☐
Support Needs Assessment ☐
Home Modifications Assessment ☐
Upper Limb Program ☐
Neurological Services ☐
Aids/Equipment Prescription ☐
Driving Assessment ☐
Vehicle Modifications Assessment ☐
Other ☐

Please provide further details:-

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Are there any risks associated with working with this client and/or the people that they live with, or who may be present during the home visit/consultation?
(e.g.: Aggressive Behaviours, Illicit Drug Use, Excessive Alcohol Use, Unsafe Building/Environment).

YES ☐ NO ☐

If you ticked YES, please provide further information:-

Does this client display Behaviours of Concern or Persistent/Complex Behaviours requiring Specialist Behaviour Support?

YES ☐ NO ☐

If you ticked YES, please provide further information:-

Client Funding Source:-

☐ Self/Private ☐ NDIS ☐ Aged Care

☐ Other (Please specify)……………………………………………………………………………...

Who should we direct the invoice/s to?...

Postal Address:-………………………...

Email:-………………………………………………………………………………………

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Once the completed referral form has been received, it will be screened to determine if the requested services can be provided by Active One. Client allocation cannot occur until a clear budget for the requested services has been provided.

For NDIS Referrals ONLY:-

NDIS Plan Attached YES ☐ NO ☐

NDIS Therapy budget allocation:

Occupational Therapy hours: ....
Exercise Physiology hours: ....
Podiatry hours: ....
Dietetics hours: ....

Do you intend for the entire Daily Living Budget to be available for Active One Services?

☐ YES ☐ NO

NDIS Number:-…………………………………… **Current NDIS Plan Expiry date:-** …./…./20…

Name of Participant's Representative (if applicable):………………………………..…………..

Email:……………………………………………………..……………………………

Postal Address:……………………………………………………………………………

(Please note: This person will be responsible for signing all service agreements / service plans on the participant's behalf)

Please tick which payment/funding method applies:

☐ Invoices to the **NDIA direct**

☐ **Self-Managed** – Invoices to be sent to:

Name:-…………………………………………….. Email:-……………………………………………..

☐ **Plan Managed** – Invoices to be sent to:

Plan Manager:-………………………………….. Email:-……………………………………………..

Any additional comments:

PLEASE FAX OR EMAIL YOUR REFERRAL TO THE ACTIVE ONE OFFICE:
Fax: (03) 87070778 OR Email: info@activeonegroup.com

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