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| REFERRAL FORM |  |

Date of Referral 10 April 2024

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| **Customer Details** |
| *This is the person who will be receiving services* |

Title: ⬜Mr ⬜Mrs ⬜Ms ⬜Other \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: «dateOfBirth»

First Name(s): «firstName» Surname: «surname»

Residential Address: «streetAdress», «suburb»

Postal Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: «email»

Home Phone: \_«homePhone» Mobile: «mobileNumber»

Health and/or Safety Concerns (e.g. pets, immunocompromised etc

Will the customer or a support person be able to use a mobile phone and/or video conferencing technology to assist with conducting an assessment in the case of a COVID lockdown or other unforeseen circumstances? ⬜Yes ⬜No

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| **Customer Availability** |
| *Please note TADWA is open Monday to Friday and does not conduct any assessments or complete any work on weekend days. TADWA Occupational Therapists conduct assessments in the morning only (between 8:30 am and 12:30 pm) and TADWA technicians generally work from 7 am to 3 pm.* |

Please indicate below any customer preferences for days and times for assessments, onsite visits, installations etc. Please note we may not always be able to accommodate preferences but will endeavour to do so wherever possible.

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| --- | --- | --- | --- | --- |
| ⬜Monday AM | ⬜Monday PM | ⬜Tuesday AM | ⬜Tuesday PM | ⬜Wednesday AM |
| ⬜Wednesday PM | ⬜Thursday AM | ⬜Thursday PM | ⬜Friday AM | ⬜Friday PM |

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| **Referrer Details** |
| *This is the person or organisation requesting services on the customer’s behalf* |

Full name: \_\_Jon Morrell Relationship to Customer: Service Provider

Organisation *(leave blank if not applicable)*: \_\_Southern Plus\_\_\_\_\_\_

Address: \_Busselton

southwesthcs@southernplus.org.au

Phone: 97915688 Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this person or a representative of this organisation required to be present to support the customer during any assessments or onsite visits?

⬜Yes ⬜No

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| **Carer, Representative, Advocate or Family Details** |
| *If not applicable please go to the next section* |

Full name: \_«primaryContact»

Organisation *(leave blank if not applicable)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this person required to be present to support the customer during any assessments or onsite visits?

⬜Yes ⬜No

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| **Customer’s Diagnosis / Health Condition** *Please provide relevant details* |

«medicalCurrent»

«medicalHistory»

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| **Equipment Currently Used** *Please provide relevant details* |

«otherEquipmentUsed»

«homeModificationsInstalled»

«mobilityAids»

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| **Service(s) Requested** |

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| **Therapy Services: Occupational Therapy** | | | |
| ⬜ | Home Environment Assessment | ⬜ | Assessment for equipment or assistive technology |
| ⬜ | Skills Training | ⬜ | Transfer Training |
| ⬜ | Self Care Assessment | ⬜ | Showering Assessment (with carer) |
| ⬜ | Other: \_ | | |

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| **Home Modifications** | | | | | |
| ⬜ | General | ⬜ | Bathroom | ⬜ | Kitchen |
| ⬜ | Other: | | | | |

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| **TACS (Technology and Computer Services)** | | | |
| ⬜ | Mobile Pendant Alarm (check) | ⬜ | Refurbished Technology Equipment |
| ⬜ | Konnekt Video Service | ⬜ | New Technology Equipment |
| ⬜ | Tech Support Agreement |  |  |
| ⬜ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Recreation and Mobility** | | | |
| ⬜ | Freedom Wheels | ⬜ | Silver Wheels (65+) |
| ⬜ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Vehicle Mobility** | | | | | |
| ⬜ | Hand Controls | ⬜ | Left Foot Accelerator | ⬜ | Wheel Chair Hoist |
| ⬜ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Custom Solutions** | |
| ⬜ | Other: FOR RECOMMENDATIONS TO BE ELIGIBLE FOR FUNDING UNDER HCP GUIDELINES REPORTS MUST EXPLICITLY LINK THE NEED WITH “AGING RELATED” FUNTIONAL DECLINE. (This may include the aged, related progression of medical conditions, age related medical conditions or other or generally a decrease in physical and/or cognitive functioning associated with ageing.) Please refer to age related functional decline and specific causes when identifying care needs in your report. Thank you. |

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| **Billing / Funding Details** |

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⬜Self Funded ⬜NDIS ⬜EFL Grant ⬜Home Care Package

⬜Other

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#### Person or Organisation Responsible for Invoice *(if different from Customer)*

Name / Organisation: Southern Cross Care WA

Billing Address: hcinvoices@scrosswa.org.au

Email: southwesthcs@scrosswa.org.au Phone: 97915688

NDIS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NDIS Plan Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send to [referrals@tadwa.org.au](mailto:referrals@tadwa.org.au) for TADWA Head Office

or [bunbury@tadwa.org.au](mailto:bunbury@tadwa.org.au) for TADWA Bunbury