Austin Health

Occupational Therapy Community Referral
VOPOTS - Veteran & Outpatient
Occupational Therapy Service

Ph: 9496 4049 Fax: 9496 2974

U.R Number .....

Surname .....

Given Name(s) .....

Date of Birth .....

AFFIX PATIENT LABEL HERE

FAH065112

Name: _____

Address: _____

_____**P/Code**_____

Date of birth:

Phone: _____ **M/F**

DVA no: _____ **Gold/ White**

NOK: _____ **NOK Phone:**_____

Referral Agency: _____

Address: _____

Phone: _____

Fax: _____

Is the client aware of the referral: ☐ **Yes** ☐ **No**

LMO/GP:_____**Ph**:_____

Medical History: _____

_____

_____

Social Situation: Lives Alone / Carer (*please specify*):_____

_____

Current Home Services: ☐ **RDNS** ☐ **HH** ☐ **MOW** ☐ **CACP** ☐ **Linkages** ☐ **Personal Alarm**

Home Visit Conducted/Previous OT Input: ☐ **Yes** ☐ **No**

Aids In Place: _____

Medication Management: Client/ Carer / Other: _____

Current Cognitive Status: _____

Current Functional Status: *(eg. mobility ,aids, self care)*_____

Falls_____

Reason For Referral

☐ **General Home Assessment** ☐ **Daily Activity Assessment/Rehab**

☐ **Personal Alarm** ☐ **Scooter/Wheelchair Prescription**

☐ **Pressure Care** ☐ **Seating Assessment**

☐ **Other** _____

Problems/Current Goals/ Rehabilitation Aims:

_____

_____

_____

Name: _____ **Signature** _____

Designation: _____ **Date**: _____/_____/_____

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