REFERRAL BOOKING FORM

e: admin@williamsot.com | www.williamsot.com
PO Box 144 Blackwood SA 5051 | p: (08) 8166 0767

Williams OCCUPATIONAL THERAPY

PARTICIPANT / CLIENT DETAILS

First Name | **Last Name**

Date of Birth | Preferred name (if applicable)

Gender ☐ Female ☐ Male ☐ Non-Binary ☐ Prefer not to say Pronouns:

Client Email

Mobile | Phone

Is the client vaccinated against COVID-19? ☐ Yes ☐ No

We continue to provide services to all clients, and this information is used for therapy service planning only

Is a translator / interpreter required? ☐ Yes ☐ No Preferred Language:

Residential Address

Suburb | State Choose | Postcode

Postal Address

Suburb | State Choose | Postcode

Living Arrangement ☐ Alone ☐ Family/Partner ☐ Support Accommodation ☐ Other

PRIMARY CONTACT FOR AN APPOINTMENT BOOKING

☐ Client ☐ Family Member ☐ Support Coordinator ☐ Other:

NEXT OF KIN DETAILS

Full Name | **Relationship**

Phone | Email

REFERRER DETAILS ☐ Self Referred

Full Name | **Organisation**

Phone | Email

Job Title / Role ☐ Support Coordinator ☐ Case Manager ☐ Treating Doctor
☐ Claims Specialist ☐ Local Area Coordinator ☐ Family Member
☐ Equipment Supplier ☐ Other:

OTHER IMPORTANT CONTACT DETAILS *e.g, Support Coordinator if not listed above*

Full Name | **Organisation**

Phone | Email

Job Title / Role ☐ Support Coordinator ☐ Case Manager ☐ Treating Doctor
☐ Claims Specialist ☐ Local Area Coordinator ☐ Family Member
☐ Equipment Supplier ☐ Other:

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NDIS NUMBER / CLAIM NUMBER

NDIS Plan Dates: Start Date End Date

FUNDING TYPE

- O NDIS Plan Manager
- O NDIS Self-Managed
- O NDIS Agency Managed
- O RTWSA
- O Lifetime Support Authority
- O Aged Care Package
- O Private / Self-Funded
- O Other:

Therapy services fall within the NDIS capacity building improved daily living budget. Williams OT charges the standard NDIS rate per hour for services in Area MMM1-5. Additional charges will apply for services in areas MMM6 – MMM7. Services are otherwise charged at RTWSA Gazetted rates.

INVOICING DETAILS

Organisation **Accounts Email**

Postal Address Phone

Suburb State Choose Postcode

REASON FOR REFERRAL

- O Light vehicle driver assessment for disability driving lessons
- O Vehicle modifications prescription – for a Driver
- O Vehicle modifications prescription – for a Passenger
- O Other vehicle driver assessment
- ☐ Single complex equipment prescription
- ☐ Multiple complex equipment prescription
- ☐ Seating / wheelchair assessment
- ☐ Complex home mods assessment
- ☐ Imminent safety or pressure risk

Additional Information:

DRIVERS LICENCE DETAILS *(if requesting a driving assessment)*

- O I do not / have never held a licence
- O My licence is medically suspended
- O I have my learners permit and completed hours in my logbook

Licence Number Class Expiry Date

Conditions:

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PRIMARY DISABILITY / INJURY / HEALTH BACKGROUND

Please provide the primary physical disability, neurological condition or psychological disability (e.g., Autism, Intellectual Disability, Cerebral Palsy, Multiple Sclerosis, Brain Injury) please advise and give details:

Date of onset of injury / disability ☐ Since birth

Please list any medications you are currently taking or attach a summary from your doctor:

TREATING GP OR SPECIALIST MEDICAL PRACTIONER DETAILS *e.g., GP, Specialist, Surgeon*

Full Name **Clinic**

Phone Email

Postal Address

Suburb State Choose Postcode

DESIRED OUTCOME

*Please provide any relevant **medical reports, medical certificates to drive, Workcover forms, current NDIS Plan, progress reports or other relevant documents** with this referral form to assist us in triaging your appointment and therapy service planning.*

TO COMPLETE THIS REFERRAL FORM

Please enter the date this form was completed and return to via email to admin@williamsot.com so that we can allocate your referral to a suitable Therapist.

EMAIL OR PRINT

Date completed:

☐ I do not wish to receive the Williams OT Newsletter

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