# HCP Referral Form

*Coast Rehab exists to support people with disabilities to engage in valued life tasks and roles. We have an experienced multidisciplinary team and provide mobile services throughout the Central Coast.*

***Please complete all sections to assist us in allocating you the best possible service.***

# PERSON

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |
| **Date of Referral:** | Click or tap to enter a date. |

# NEXT OF KIN

|  |  |
| --- | --- |
| **Name:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. |
| **Email:** | Click or tap here to enter text. |

# DIAGNOSIS

|  |  |
| --- | --- |
| **Diagnosis:** | Click or tap here to enter text. |
| **Date of onset (if applicable):** | Click or tap to enter a date. |
| **Cause (if applicable):** | Click or tap here to enter text. |
| ***Please attach relevant medical reports and information to this referral:***  Previous allied health reports attached?Click or tap here to enter text.  Medical reports attached? Click or tap here to enter text. | |
| ***Please list other relevant contacts (medical, allied health team)***  Click or tap here to enter text. | |

# REFERRER

|  |  |
| --- | --- |
| **Name**: Click or tap here to enter text. | **Location**:  Click or tap here to enter text. |
| **Phone number:** Click or tap here to enter text. |  |
| **Email:** Click or tap here to enter text. | **Relationship to participant:**  Click or tap here to enter text. |

# HCP FUNDING

|  |  |
| --- | --- |
| **Care Provider:** | Click or tap here to enter text. |
| **Care Coordinator:** | Click or tap here to enter text. |
| **Coast Rehab Invoice to:** | Click or tap here to enter text. |
| Does the participant have funding in their Home Care Package | Yes  No |

# SPECIALIST/ GP DETAILS

|  |  |
| --- | --- |
| Name:  Click or tap here to enter text. | Name:  Click or tap here to enter text. |
| Phone: Click or tap here to enter text. | Phone: Click or tap here to enter text. |
| Location:  Click or tap here to enter text. | Location:  Click or tap here to enter text. |

# REASON FOR REFERRAL

|  |
| --- |
| **Occupational Therapy** |
| OT Functional Assessment Click or tap here to enter text.  Home Safety Assessment Click or tap here to enter text.  Wheelchair Mobility and Seating Review Click or tap here to enter text.  Bed Assessment Click or tap here to enter text.  Manual Handling Review Click or tap here to enter text.  SDA Assessment Click or tap here to enter text.  Management of Progressive Neurological Disorders Click or tap here to enter text.  Other Click or tap here to enter text. |
| **Physiotherapy** |
| Mobility Assessment Click or tap here to enter text.  Falls Risk Assessment Click or tap here to enter text.  24 Hour Positioning Click or tap here to enter text.  Exercise and Wellbeing Click or tap here to enter text.  Hydrotherapy Click or tap here to enter text. |
| **Speech Pathology** |
| Communication Assessment Click or tap here to enter text.  Assistive Technology Assessment Click or tap here to enter text.  Swallowing Assessment and Intervention Click or tap here to enter text. |

|  |
| --- |
| **Dietitian** |
| Nutrition Assessment and Review Click or tap here to enter text.  Enteral Nutrition (PEG Feeding) Click or tap here to enter text.  Other Click or tap here to enter text. |

# ABOUT THE PARTICIPANT

|  |  |
| --- | --- |
| **Additional Relevant Information** | **Comments** |
| Speech and Communication Difficulties? | Click or tap here to enter text. |
| Mobility Impairment? (use of aids) | Click or tap here to enter text. |
| Cognitive Issues? | Click or tap here to enter text. |
| Behaviour Support Plan? | Attached?  Yes  No |
| Housing History? *e.g. past 5 years, and description of what did and didn’t work for the client (for SIL or SDA report requests)* | Click or tap here to enter text. |
| **Current Risks/Trauma History?** *e.g. self-harm or suicidal behavior; domestic violence; risks within home environment; substance-use; anger or aggression; others.* | Click or tap here to enter text. |

# SUMMARY OF ALLOCATION FOR THERAPY SUPPORTS

|  |  |  |
| --- | --- | --- |
| **Service:** | **Hours:** | **Objectives:** |
| Occupational Therapy | Click or tap here to enter text. | Click or tap here to enter text. |
| Physiotherapy | Click or tap here to enter text. | Click or tap here to enter text. |
| Speech Therapy | Click or tap here to enter text. | Click or tap here to enter text. |

**Please send to** [**Admin@coastrehab.com.au**](mailto:Admin@coastrehab.com.au)

**Thank you for your referral to Coast Rehab.**