# 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**

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