Focus on Function
Collaborative Therapy Solutions

REFERRAL FOR OCCUPATIONAL THERAPY SERVICE

Welcome to Focus on Function! Thank you for filling in this referral form. This will help with getting our services started.
To complete this form, you will need:

- ✓ Information on the participant who requires the service.
- ✓ Injury / disability related information.
- ✓ Best contact details for us to keep you update with the progress of your referral and for when we start working with you.
- ✓ About 5 – 10 minutes of your time to complete the form.

The more information we have, the better we can help!
If you need assistance with any aspect of the referral process, please contact our customer support team – 0493 133 667.

PARTICIPANT DETAILS:	
Full name:	
Date of Birth:	Age:
Do you identify as Aboriginal or Torres Strait Islander?	Yes No Prefer not to answer
Address:	Address:
	Please circle if the participants home is: Private rental Privately owned Supported accommodation Public Housing Residential aged care
Email address for participant:	Email: ☐ I do not have an email address / please do not contact me via email
Phone number for participant	Home: Mobile: ☐ Please do not contact participant via phone:
Contact details to arrange appointments:	☐ Participant (details as above): If not the participant, please provide details for an alternative contact: Name: Relationship: Do you live with the participant? Yes No Phone:

	Email: Postal address: Confirm we can send text message reminders for appointments: Yes / No ☐ Participant mobile: ☐ Alternative mobile contact number listed above: ☐ Other:
Nominee/Guardian:	Is the Nominee or Guardian the same as the alternative contact details previously: Yes / No If this information is different, please provide the following details: Name: Relationship: Phone: Email:
GP:	Name: Contact Details:
FUNDING DETAILS:	
Funding Body:	
Participant / Claim Number:	
Contact person:	Name: Role: Phone: Email:
REASON FOR REFERRAL:	
Diagnosis:	
Other disability or health complications:	
Brief History:	
OT Services Required:	Please circle all that apply: Activities of Daily Living (ADL) Assessment Assistive Technology / Equipment Home Modifications Manual Handling review Skin Integrity review Other:_____

Any other complexities that we need to know to allow us to do our job well?	
Please tick all that apply:	☐ Is the participant at risk of falls or has a history of falls? ☐ Are the current disability related supports insufficent? ☐ Is the home layout limiting participation or safety? ☐ Is the participant at considerable risk of pressure injures? ☐ Does the participant have poor fitting disability related equipment?
REFERRAL SOURCE:	
Name:	
Contacts:	Email: Phone:
Organization:	
Date of referral:	
SAFETY ISSUES:	
Are there any safety concerns that should be considered for home visiting.	This might include a history of aggression, firearms, unrestrained pets. ☐ Yes Please provide details: Please confirm best contact details to gather further information: ☐ No

☐ Please confirm the participant/carer is aware and consenting to this referral: YES

Return completed referral form, along with CURRENT NDIS PLAN GOALS AND BACKGROUND REPORTS TO: admin@focusonfunction.com.au

We are a service that embraces supporting Occupational Therapy university students. We will always seek your consent to have student's participant in your OT services.

Thank you for taking the time to complete this form. We are looking forward to working with you!

A friendly team member will be in contact with you soon.

If you have any concerns, please contact our customer support team - 0493 133 667.

If you have any change in contact details or circumstances, please keep our wonderful customer service team up to date.

Phone: 0493 133 667 Email: admin@focusonfunction.com.au
Post: PO Box 873 Gunnedah NSW Office: 88 Barber St Gunnedah NSW

Participant Name: