

**OCCUPATIONAL
THERAPY
REFERRAL FORM**

Please fax to 4772 5320
Phone: 4772 5191
Email: info@nqtherapyservices.com
Web: www.nqtherapyservices.com

Patient/Client Details:

Name: Date of Referral:
Age: Date of Birth:.....
Address:..... Telephone; (H)
..... (W)

Treating Doctor Details:

Doctor:
Address / Or Stamp:

Funding: Private / Medicare / Workcover or Self Insurer / CTP Insurer/ DVA / Other

Diagnosis and Date of Onset:
.....
Relevant Medical History;
.....
Current Medications;

Referral to North Queensland Occupational Therapy Services for:

- | | |
|--|--|
| <input type="checkbox"/> Home Visit | <input type="checkbox"/> Workplace Assessment / Rehab |
| <input type="checkbox"/> Home Modifications/Equipment | <input type="checkbox"/> Brain Injury Assessment / Rehab |
| <input type="checkbox"/> Neuromotor Retraining of Upper Limb | <input type="checkbox"/> Pressure Garment Prescription |
| <input type="checkbox"/> Driving Assessment | <input type="checkbox"/> Office Ergonomics Assessment |
| <input type="checkbox"/> Wheelchair Prescription | <input type="checkbox"/> Hand Dominance Retraining |
| <input type="checkbox"/> Posture Retraining | <input type="checkbox"/> Personal Alert Alarm |

Physical Status:

Visual.....
Hearing:

Communication:

Needs Interpreter: Yes No (Circle)

Non-English Speaking Background: Yes No (Circle)

Physical Function:

Comment on any physical problems that the person may have in relation to:

- * muscle strength
- * range of movement
- * sensation
- * tone/spasm
- * coordination
- * endurance
- * reaction time
- * mobility
- * transfers
- * balance

.....
.....
.....

Perceptual/Cognitive Function: (Circle)

- Not impaired
- Impaired Give details:

.....

Psychiatric Condition: (Circle)

- Not present
- Present Give details;

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ADDITIONAL COMMENTS:

.....
.....

DOCTOR'S APPROVAL

I, Dr.....of.....(Medical Group)
 give approval for(client/patient name) to undertake an
 Occupational Therapy Assesment/Treatment with North Queensland Therapy Services.
 Signed:.....Date:.....