People First Allied Health

CARE TAILORED TO YOU

REFERRAL FORM

Name		DOB	
Address			
Email		Phone	
Does the client identify as First Nations People? ☐ Yes ☐ No			

NDIS Number	
Plan Type ☐ NDIA Managed ☐ Self-Managed ☐ Plan Managed	
Plan Dates (start and End date)	
Plan Manager Details	
Email for invoices	

BOOKING THE APPOINTMENT	
Contact Person for Appointment	☐ Please contact participant directly ☐ Please contact person below
Details of Person to Book Appointment With:	
☐ Private Client ☐ TAC Client ☐ Work Cover Client ☐ Medicare Client ☐ NDIS Client	

REFERRER'S DETAILS	
Name	
Email	
Reason for Referral	
Approved Disability	
☐ OT ☐ SPEECH ☐ PSYCHOLOGY ☐ PHYSIO ☐ RECOVERY COACH/SC	
FUNDS ALLOCATED/Hours	

Email: info@alliedhealth.com.au
Phone: 1300 850 407

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RISK ASSESSMENT

To be completed for all new initial assessments that require a home visit or People First Allied Health is visiting the home for the first time.

Client Name:	Phone Number	
Location for appointment:		
Carer:	Existing Client ☐	New Client ☐

1.General	YES	NO	Details:	Risk Rating (High, Medium, Low)
1a. Does the client consent to a home visit?				
1b. Has the risk assessment been completed with the client/carer present?				
2.Acess to the property				
2a. Are there any difficulties finding the property? Please provide any information that would be helpful to the OT visiting. i.e. parking, which door to enter etc.				
3. Hazards				
3a. Are there any trip or slip hazards?				
3b. Pets or animals?				
3c. Is there adequate mobile phone reception?				
4. Occupants				
4a. Does the client or other occupants smoke? If yes, we ask that smoking is refrained during the assessment for the comfort of the OT				
4b. Does the client speak English?				
4c. Does the client require an interpreter?				
4d. Does the client require support for the visit, and has this been organised?				
4e. Are there any known weapons or firearms in the house?				
If yes, are they secured appropriately?				
4f. Are there any particular religion or cultural sensitivities to be aware of?				
4g. Is there known substance abuse amongst occupants or visitors?				
If yes, what?				

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4h. Does the client or other occupant have history of violent or aggressive behaviour?				

5. Please note any additional information that you think might be relevant to the safety of our team.

Name of person completing the form:		**Date:**
Signature:		

Please note: It is important that you contact **People First Allied Health if any of the above information changes to ensure the safety of our team**

*Please email complete form to **Info@peoplefirstalliedhealth.com.au***

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