**Referral Form for Occupational Therapy**

**UnitingCare Allied Health Unit (Specialist Disability)**

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| **Person’s Details** |  |
| First Name       | Last Name       |
| Date of Birth       | Gender       |
| Disability       |  |
| Address        |
| Phone (home/work)       | Mobile       |
| Email       |

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| **Referrer’s Details** |
| Has this referral been discussed with the person / their parents / guardian / plan nominee?[ ] Yes [ ] No |
| Referrer’s Name       |
| Relationship to the person       |
| Phone (home/work)       |  Mobile       |
| Email       |

|  |  |
| --- | --- |
| **Reason for Referral**Please indicate what you would like assistance with. (You can tick more than one.) |  |
| [ ] Assistive Technology | [ ] Computer Access | [ ] Functional Assessment |
| [ ] Home Modifications | [ ] Sensory Processing | [ ] Vehicle Modifications |
| [ ] Other:      |

 **Please return this form via**

*Email:* *AlliedHealthUnit@uccommunity.org.au*

*or*

*Post: UnitingCare Allied Health Unit (Specialist Disability)*

 *PO Box 468*

 *Annerley QLD 4103*

**Authorisation and Contacts**

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| **Review and Version Control** |
| **Version** | **Authorised By** | **Initial Approval Date** | **This Review Date** | **Change History and Superseded Documents** | **Next Review Date** |
| 1 | Manager DLU | 1/2/19 | 1/2/19 | New document | 1/2/2021 |

Signed Copy held with Specialist Disability Policy and Improvement Coordinator.