Independent Living Centre Tasmania

Local call: 1300 885 886
Email: referrals@ilct.com.au

Independent Living Centre Tasmania (ILCT)

Referral Form

Referral Date:	Received:

Personal Details

Name:		Gender: ☐ M ☐ F ☐ Other
Address:	Post Code:	Date of Birth: Age:
Daytime phone:	Mobile:	Preferred method of contact: ☐ Phone ☐ Mobile ☐ Email
Email:		Is this person aware of the referral? ☐ Yes ☐ No
NDIS participant number:	Plan Dates: from ____/____/____ to ____/____/____	
Are you of Aboriginal or Torres Strait Islander origin: ◯ Yes ◯ No ◯ Prefer not to say		

Referrer Details

Name:	Phone:
Email:	Fax:
Organisation:	
Address:	

Falls history & safety risk:

Has the person had any falls recently? ☐ Yes ☐ No

If yes, please specify how many falls over the last 12 months: _____

Has the person had any choking episodes in the last 12 months? ☐ Yes ☐ No

Does the person live alone? ☐ Yes ☐ No

Is there anything we should be aware of, such as safety risks (medical, behavioural, environmental), urgency of referral, palliative care, or discharge planning?

Diagnosis and Relevant Medical History

Mobility Status

Please specify mobility aids used. Does this person need help from other people?

Reason for Referral

Allied Health Services

A health professional will work with you to assess and provide recommendations in the area(s) requested. A report will be provided upon request after the assessment.

Occupational Therapy (OT) / *Physiotherapy* (PT) / *Speech-Language Pathologist* (SLP)
Allied Health Assistant (AHA)

	Functional and Life skills development (OT/ AHA) *Please highlight relevant fields:* ☐ Community Access and Transport ☐ Domestic Skills Development ☐ Social Skills Development		☐ Scooter and Power Mobility Training ☐ Self-Care Skill Development ☐ Recreation and Leisure Skills Development - Other
☐	Functional assessment (OT)	☐	Home modification assessment (OT)
☐	Support needs assessment and care planning (OT)	☐	Access consultancy services for public buildings (OT)
☐	Specialist Disability Accommodation (SDA) assessment (OT)	☐	Functional Communication Assessment (SLP)
☐	Ergonomics and workplace audit (OT)	☐	Mealtime management (SLP)
☐	Pragmatic (Social) Communication Skills (SLP)	☐	Manual handling assessment (PT/OT)
☐	Mobility assessment (PT)		Other (Please specify):

Assistive Technology Assessments

A health professional will work with you to evaluate assistive technology options to identify the assistive technology or design that best fit your needs. A report will be provided upon request after the assessment.

☐	Alternative & Augmentative Communication (AAC)	☐	Alternative computer access options
☐	Telecommunication options (phones, personal alarms, etc.)	☐	Smart home technology / home automation
☐	Assistive technology for literacy support	☐	Assistive technology for daily living activities (e.g. eating, drinking, dressing and medication management etc.)
☐	Commodes and other hygiene related assistive technology (e.g. toilet equipment, shower stool, bath board etc.)	☐	Assistive technology for meal preparation and household tasks
	General seating ☐ Dining chair ☐ Lounge chair/recliner	☐	Ergonomic office seating
	Wheelchair prescription ☐ Manual ☐ Power	☐	Scooter assessment
☐	Assistive technology for mobility (e.g. walking stick, crutches, walking frame etc.)	☐	Assistive technology for transfers (e.g. hoist, standing aids, transfer belt etc.)
☐	Adjustable beds & bed equipment	☐	Assistive technology for pressure management
☐	Assistive technology for low vision	☐	Assistive technology for hearing impairment
	Other (please specify):		

Training Services

A health professional will deliver training for you and your support team in the area(s) requested.

☐	Introduction to Assistive Technology	☐	Disability Awareness
☐	Manual handling training	☐	Pressure management training
☐	Wheelchair training	☐	Scooter training
☐	AAC and complex communication needs	☐	Active support
☐	Assistive technology for literacy support	☐	Mealtime support
☐	Employing people with ASD in workplace	☐	Smart Assistive Technology for carers
☐	Office ergonomics	☐	Universal design/building & design/accessible environments
	Other (Please specify):		

Referral Details

Please provide further details regarding the referral requirements:

Who should be involved in this process? Please identify a key liaison person (e.g. keyworker, etc.).

Who else has been involved? Are there any recent health and education assessment reports available? If so, please attach.

What interventions has this person received related to this issue?

Has this person had a recent change in circumstances or medical conditions?
Please specify:

If there is not enough space to provide full details, please write the information on a separate page.
☐ Tick box if additional information page/s have been completed.

Additional Information

Does this person need an interpreter? ☐ Yes ☐ No

If yes, please state the language: _____

Will this person come into the centre (ILCT)? ☐ Yes ☐ No
Is a home visit required? ☐ Yes ☐ No

Who does this person live with? _____

Primary Contact Details

Name:	Relationship to this person:
Address:	Home phone: _____ Mobile phone:

General Practitioner/Specialist

Name:	Phone:
Address:	

Relevant services who are involved with my care:

Name:	Phone:
Address:	

Name:	Phone:
Address:	

☐ Yes, there are other individuals, organisations or services I wish ILCT to be aware of.
I have attached them separately.

Documentation Requirements

Do you want a report? ☐ **Yes** ☐ **No** **If yes, please tick relevant option below:**
☐ Formal report ☑ Progress notes ☐ Verbal report

Who is the report to be sent to?
List below all parties and contact details or complete an ILCT Consent to Exchange Information form.

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Payment

Who will be paying for this service?

☐ Private/self ☐ Organisation ☐ Others:_____

☐ NDIS Agency Managed ☐ NDIS Plan Managed ☐ NDIS Self-Managed

Payment contact details:

Name: _____

Email: _____

Address: _____

NDIS Support Type Please tick relevant option/s below:	Hours/$ available for ILCT		NDIS Line Item Number
☐ Assistive Technology			
☐ Development - Life skills			
☐ Home modifications			
☐ Therapeutic Supports/Allied Health – Occupational Therapy, Speech Pathology, Physiotherapy			
☐ Other – please specify			
☐ Budget for Travel	Hours/$		
	Km*		

NDIS Goals - please list. (You may also wish to attach your NDIS Plan - Optional):

MMM6-MMM7 only (Modified Monash Model)

You may be contacted by us for provision of an estimate for the services you require. All referrals are assessed on clinical need and urgency. You will be notified of the outcome of your referral. Once the referral has been accepted and payment authorisation received, an ILCT staff member will contact you when we have capacity to see you. This may mean you are placed on a waiting list in the interim.