

Living Centre
Tasmania

Issue Date: 12/11/2025

Referral form

Referral Date:	rral Date: Received:				
Personal details					
Name:			Gender: M F Other		
Address:		Post Code:	Date of Birth:		
On Care about	T & A = L:1 = .		Age:		
Daytime phone:	Mobile:		Preferred method of contact:		
Email:			Is this person aware of the referral? Yes No		
Are you of Aboriginal or Torres Strai	it Islander origin?	Yes N	o Prefer not to say		
NDIS participant number:		Plan Dates:	from/		
			to/		
Client/Participant preferences: (E.g. gender of workers/preferences about therapist/staff, environment/venue for initial appointment, preferred day of the week and time for appointments, communication type etc)					
Client/Participant culture, values and beliefs: (optional)					
Referrer details					
Name:			Phone:		
Email:		Fax:			
Organisation:					
Address:					

Phone: 1300 452 827

referrals@ilct.com.au



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Falls history and 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?					
Diamagia and valous at madical history					
Diagnosis and relevant medical history					
Do you have a medical action plan/ behavioural support plan. Pleas	se attach a copy				
Yes No	Unknown				
Medical Action Plan					
Anaphylaxis Asthma Seizure/Epile	psy Behaviour Support				
Other - Please Specify					
Mobility status					
Please specify mobility aids used. Does this person require help fr	rom others for their mobility?				

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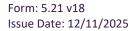
Reason for referral

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)

 Scooter and Powered Mobility Training Self-Care Skill Development Recreation and Leisure Skills Development Other 			
Home modification assessment (OT)			
Specialist Disability Accommodation (SDA) assessment (OT)			
Ergonomics and workplace audit (OT)			
Balance assessment (PT)			
Manual handling assessment (PT/OT)			
Lymphoedema assessment & management (PT)			
Exercise prescription (PT)			
Social Skills Therapy (SLP)			
Fluency Therapy (SLP)			
Speech Therapy (SLP)			
Language Therapy (SLP)			
Voice Therapy (SLP)			
Mealtime management Therapy (SLP)			



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Assis	Assistive Technology Assessments				
	alth professional will work with you to evaluate assistiv	ve 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 Alternative computer access options				
	(AAC)	·			
	Telecommunication options	Smart home technology / home automation			
	(phones, personal alarms, etc.)				
	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	Assistive technology for meal preparation			
	technology (e.g. toilet equipment, shower stool,	and household tasks			
	bath board etc.)				
	General seating	Ergonomic office seating			
	☐ Dining chair ☐ Lounge chair/recliner				
	Wheelchair prescription	Scooter assessment			
	☐ Manual ☐ Power				
	Assistive technology for mobility (e.g. walking	Assistive technology for transfers			
	stick, crutches, walking frame etc.)	(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):				

Referral details

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 Pressure management training			
Manual handling 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):				



Form: 5.21 v18 Issue Date: 12/11/2025

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 No Does this person need an interpreter? Yes If yes, please state the language: Will this person come into the centre (ILCT)? Yes No

Is a home visit required?

Who does this person live with?

Yes

No



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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:				
Vos there are other individuals expanisations are consisted living II CT	to be aware of			
Yes, there are other individuals, organisations or services I wish ILCT I have attached them separately.	to be aware or.			
Decumentation requirements				
Documentation requirements Do you want a report? Yes No If yes, please t	ick relevant option below:			
Formal report Progress no				
Who is the report to be sent to?				
List below all parties and contact details or complete an ILCT Consent to Exchange Information form.				

Payment

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Wh	o will be paying for this se	rv <u>ice</u> ?		_	_		
Ш	Private/self		Organisation			Others:	
	NDIS Agency Managed		NDIS Plan Managed		NDIS Self-Managed		
Pay	ment contact details: Name:						
	Email:						
	Address:						
NDI	S Support Type				Ηοι	urs/\$ available	NDIS Line Item
	Please tick relevant option/s below:				ILCT	Number	
Assistive Technology							
Development - Life skills							
Home modifications							
Therapeutic Supports/Allied Health – Occupational Therapy, Speech Pathology, Physiotherapy							
	Other – please specify						
☐ Budget for Travel		-		urs/\$			
			Km				
NDIS Goals - please list. (You may also wish to attach your NDIS Plan - Optional):							
l							

*MMM6-MMM7 only (<u>Modified Monash Model</u>)

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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.