Independent Living Centre Tasmania

Local call: 03) 6335 9200
Email: referrals@ilct.com.au

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:
Email:		Is this person aware of the referral? ☐ Yes ☐ No
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:	

PO Box 37,
PERTH, TAS 7300

337 Argyle Street,
NORTH HOBART TAS 7000

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?

Diagnosis and relevant medical history

Do you have a medical action plan/ behavioural support plan. Please attach a copy

◯ Yes ◯ No ◯ Unknown

Medical Action Plan Type

◯ Anaphylaxis ◯ Asthma ◯ Seizure/Epilepsy ◯ Behaviour Support

◯ Other - Please Specify

Mobility status

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

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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)

	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)		Specialist Disability Accommodation (SDA) assessment (OT)
	Access consultancy services for public buildings (OT)		Ergonomics and workplace audit (OT)
	Mobility assessment (PT)		Balance assessment (PT)
	Postural dysfunction Assessment (PT)		Manual handling assessment (PT/OT)
	Chronic and persistent pain assessment & management (PT)		Lymphoedema assessment & management (PT)
	Women's Health (PT)		Exercise prescription (PT)
	Social Skills Assessment (SLP)		Social Skills Therapy (SLP)
	Fluency Assessment (SLP)		Fluency Therapy (SLP)
	Speech Assessment (SLP)		Speech Therapy (SLP)
	Language Assessment (SLP)		Language Therapy (SLP)
	Voice Assessment (SLP)		Voice Therapy (SLP)

	Mealtime management Assessment (SLP)		Mealtime management Therapy (SLP)
	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.