Independent Living Centre Tasmania

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

My Aged Care 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
Primary Contact Person:		Contact:
Client preferences (including culture, values and beliefs):		
Does this person need an interpreter? ◯No / ◯Yes (Please state the language: _____)		
Level of MAC funded support (Please circle)- ◯Nil ◯STRC ◯CHSP ◯HCP 1 ◯2 ◯3 ◯4		

Referrer details

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

Falls history and safety risk

Has the person had any falls recently? No ◯ Yes. ◯ No. of falls in last 12 months: ____

Has the person had any choking episodes recently? No ◯ Yes. ◯ No. of incidents in last 12 months: ____

Does the person live alone? No ◯ Yes ◯

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

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

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General Practitioner/Specialist

Name:	Phone:
Address:	

Please attach a copy of GP medical summary if available.

Mobility status

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

Reason for referral (Please tick appropriate)

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***

□ Functional assessment
□ Home modification assessment
□ Support needs assessment & care planning
□ Mobility scooter assessment
□ Equipment recommendations-
- □ General seating
- □ Wheelchair prescription (□ Manual / □ Powered)
- □ Adjustable bed & equipment
- □ Equipment for low vision
- □ Equipment for daily living activities(meal preparation, eating, showering etc)
- □ Equipment for transfers (hoist, standing aids etc)
- □ Equipment for pressure management
- □ Alternative computer access options
- □ Telecommunication options (phones, personal alarms, etc.)
- □ Smart home technology / home automation

☐ ***Physiotherapy***

□ Mobility assessment
□ Balance assessment
□ Postural dysfunction Assessment
□ Manual handling assessment
□ Chronic and persistent pain assessment & management
□ Lymphoedema assessment & management
□ Exercise prescription
□ Women's Health
□ Equipment for mobility (e.g. walking stick, crutches, walking frame etc.)

☐ ***Speech-Language Pathologist***

□ Social Skills assessment /therapy
□ Fluency assessment
□ Speech assessment
□ Language assessment
□ Voice assessment
□ Fluency therapy
□ Speech therapy
□ Language therapy
□ Voice therapy
□ Mealtime management Assessment
□ Mealtime management therapy
□ Equipment for Alternative & Augmentative Communication (AAC)

☐ **Training Services (please list): _____**

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

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Referral details

Please provide further details regarding the referral request:

Documentation requirements (please tick relevant option below)

Formal report ◯ Progress notes ◯ Verbal report ◯

List below all parties and contact details for the report to be sent to:

Payment

Who will be paying for this service?

◯ Private/self ◯ Organisation ◯ Others: _____

Payment contact details:

Name: _____

Email: _____

Address: _____

You may be contacted by us for provision of a fee 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.