

**PROVIDER ADDRESS:**

2 Aver Ave DAW PARK SA 5041

**Fax: 8276 3377**

**Email: admin@enhanceot.com.au**

©Enhance Occupational Therapy Pty Ltd 2018



**Enhance<sup>OT</sup>**

**Occupational  
Therapy**

www.enhanceot.com.au

Telephone: **8276 3355**

**REFERRAL TYPE** Urgent:

- HOSPITAL DC DC DATE: \_\_\_\_\_
- ACUTE CARE
- GENERAL OT ASSESSMENT
- TREATMENT/REHABILITATION
- ADL/FUNCTION REPORT

**FUNDING TYPE**

**DVA HEALTH CARD**

Rehabilitation Appliance Program (RAP):  
DVA Health Card used as payment with  
provision of either listed items:

- LETTER of REFERRAL
- DVA FORM- D904 REQUEST
- GOLD  WHITE

DVA FILE NO: \_\_\_\_\_

**HOSPITAL FUNDING SITE:** \_\_\_\_\_

**PRIVATE FEE**  
PRIVATE HEALTH FUND: \_\_\_\_\_  
MEMBER NO: \_\_\_\_\_

**MEDICO-LEGAL ADL REPORT**

**COMPENSABLE FUND:** \_\_\_\_\_  
CLAIM NO: \_\_\_\_\_

**HOME CARE PACKAGE LEVEL:** \_\_\_\_\_  
PACKAGE PROVIDER: \_\_\_\_\_

- NDIS** NDIS No: \_\_\_\_\_
- REQUEST ENHANCE OT INTAKE FORM
- REQUEST SERVICE AGREEMENT
- PARTICIPANT CONSENTS TO ABOVE

**REFERRAL FOR OCCUPATIONAL THERAPY**

**Surname:** \_\_\_\_\_ **First:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Suburb:** \_\_\_\_\_ **Postcode:** \_\_\_\_\_

LOCATION OF CONSULT  LISTED ABOVE  INPATIENT  **Other:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_ **Home Ph:** \_\_\_\_\_

**Alternate Contact:** \_\_\_\_\_  CONTACT ALTERNATE TO ARRANGE CONSULT

**Alternate Phone:** \_\_\_\_\_  ALTERNATE IS REQUIRED AT CONSULT (CLIENT CONSENTS)

**Usual GP:** \_\_\_\_\_ **GP Phone:** \_\_\_\_\_

**GP Location:** \_\_\_\_\_

**Medicare No:** \_\_\_\_\_ **Ref No:** \_\_\_\_\_

Aboriginal and/or Torres Strait Islander origin? Yes  No:  NOT RECORDED

Language/Communication support required:  INFORMAL FAMILY  FORMAL INTERP

Provide details: \_\_\_\_\_

**MEDICAL HISTORY/CONDITION:**

**REFERRAL REQUEST DETAILS:**

All known risk factors to client & visiting OT are provided YES

**REFERRER SIGNED:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Referrer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

<b>OFFICE USE ONLY</b>	<b>ATTACHMENTS FILED</b>	<b>COMPLIANCE CHECK</b>	<b>EOT ACTIONS REQUIRED</b>
	<input type="checkbox"/> DC SUMMARY <input type="checkbox"/> LETTER OF REFERRAL	<input type="checkbox"/> COMPLETE INFO	<input type="checkbox"/> ADDITIONAL ITEMS REQUIRED
	<input type="checkbox"/> REPORTS <input type="checkbox"/> FORMS	<input type="checkbox"/> DVA RAP	<input type="checkbox"/> SEND NDIS INTAKE FORM
<input type="checkbox"/> HEALTH SUMMARY <input type="checkbox"/> RISK ASSESSMENT (EXT)	<input type="checkbox"/> EXISTING CONTRACT	<input type="checkbox"/> EOT RA REQUIRED _____	