

**PROVIDER ADDRESS:**

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**Enhance<sup>OT</sup>****Occupational  
Therapy**

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

OFFICE USE ONLY

**ATTACHMENTS FILED**

- ☐ DC SUMMARY ☐ LETTER OF REFERRAL
- ☐ REPORTS ☐ FORMS
- ☐ HEALTH SUMMARY ☐ RISK ASSESSMENT (EXT)

**COMPLIANCE CHECK**

- ☐ COMPLETE INFO
- ☐ DVA RAP
- ☐ EXISTING CONTRACT

**EOT ACTIONS REQUIRED**

- ☐ ADDITIONAL ITEMS REQUIRED
- ☐ SEND NDIS INTAKE FORM
- ☐ EOT RA REQUIRED \_\_\_\_\_