In-Home Allied Health
Referral Form

Plena Healthcare

136 033 community@plenahealthcare.com.au **Date Of Referral:** _____

Consumer Details *Required To Process Referral

Name: _____ **Date of Birth:** _____

Phone Number: _____ **Gender:**

☐ Female ☐ Male ☐ Transgender/ Non Binary/ Gender Diverse

Email Address: _____ ☐ Prefer not to answer

Client Address: ☐ Home ☐ Facility **Preferred Booking Contact:**

☐ Phone ☐ Email ☐ Contact via NOK ☐ Contact via Case Manager

_____

Next Of Kin Contact Details / Alternative Contact Person *Required To Process Referral

Name: _____ **Relationship:** _____

Phone Number: _____ **Alternative Number:** _____

Email Address: _____

Referring Person / Company Details *Required To Process Referral

Name: _____ **Email Address:** _____

Company: _____ **Postal Address:** _____

Phone Number: _____ _____

Payment Type + Invoicing *Required To Process Referral

☐ Home Care Package ☐ CHSP ☐ Medicare CDM/EPC ☐ Other (please specify)

☐ STRC ☐ Private ☐ NDIS _____

Provider Name: _____ **Invoice Contact Name:** _____

Coordinator's Name: _____ **Email Address for Invoices:** _____

Preferred Appointment Type *Required To Process Referral

Location: ☐ Face to face ☐ Telehealth ☐ No preference **Preferred Language:** _____

Therapist Gender: ☐ Female ☐ Male ☐ No preference **Is an interpreter required?** ☐ Yes ☐ No

Regular Unavailability (please provide days and times) Appointments, Care Workers, Etc.

Referral Details

☐ Occupational Therapy

- ☐ Mobility and transfers: *area* _____
- ☐ Falls review: *comment* _____
- ☐ Equipment review: *comment* _____
- ☐ Powered Mobility Device or scooter assessment:
- ☐ *Please describe: i.e. Currently driving? Has this person recently been reviewed by GP? When?* _____
- ☐ Home safety assessment: *area of concern* _____
- ☐ Home environment and potential modifications:
  Please describe area of concern i.e. unable to access property (front, back, side), bathroom, toilet, bedroom, garden
  _____
- ☐ Assistive technology
- ☐ Activities of daily living retraining: *please describe*
  _____

☐ Dietetics

- ☐ Dietary assessment
- ☐ Meal planning
- ☐ Low or change to appetite
- ☐ Weight management
- ☐ Nutrition support (oral supplements and enteral feeding)
- ☐ Chronic health management
- ☐ Dysphagia/texture modified diet planning
  (please refer in conjunction with a Speech Pathologist)

☐ Physiotherapy

- ☐ Pain: *body region* _____
- ☐ Mobility and transfers: *area of concern* _____
- ☐ Strength or range of motion: *body region* _____
- ☐ Falls review: *comment* _____
- ☐ Post hospitalisation or recent surgery: *describe* _____
- ☐ Safety in the home: *area of home* _____

☐ Speech Pathology

- ☐ Swallow/Eating/Drinking Support
- ☐ Mealtime Assessment Plan
- ☐ Communication Support
- ☐ Voice Therapy
- ☐ Dysphagia/texture modified diet planning
  (please refer in conjunction with a Dietitian)

☐ Podiatry

- ☐ General Foot Care
- ☐ Corns, Callus or Pressure Area
- ☐ Ingrown Nails
- ☐ Footwear Assessment
- ☐ Biomechanical assessment for foot pain
- ☐ Biomechanical assessment for orthotic therapy

Additional Pre-Approved Hours: ☐ Yes _____ ☐ No (Assessment only)

Areas of Concern

Consumer Primary Goal

Medical History

Primary Diagnosis

Recent Falls, Surgery or Risks
Examples: Surgery in last 12 months, Falls in the last 6 months

Cognitive Diagnosis
Dementia, Alzheimers or specific precautions

Specific Precautions
Examples: Mobility aids, 2 x assist, communicable disease

Other Relevant Medical Information

NDIS Clients Only:

☐ Agency Managed ☐ Plan Managed ☐ Self-Managed

Participant ID:

Plan Start Date:

Plan End Date:

Plan Manager Name:

Plan Manager Contact Details:

Funding Area:

Support Carer / Worker Name: (if applicable)

Support Carer / Worker Contact Details: (if applicable)

Support Carer / Worker Working Hours: (if applicable)

Goals:

Other Relevant Information

All referrals to be sent directly to **community@plenahealthcare.com.au** for triage and processing.