

In-Home Allied Health Referral Form



 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
 Prefer not to answer

Email Address: _____

Consumer Address: Home Facility

Preferred Booking Contact:
 Phone Email Contact via NOK Contact via Care Partner

Next Of Kin Contact Details / Alternative Contact Person *Required to process referral

Name: _____ **Relationship:** _____

Phone Number: _____ **Email Address:** _____

Referrer Details *Required to process referral

Name: _____ **Email Address:** _____

Company: _____ **Email Address for invoices:** _____

Phone Number: _____

Support at Home - Level: _____ Restorative Care Private CHSP Medicare CDM/EPC


Other (please specify): _____

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

Occupational Therapy

 Click here to view our brochure

Package options:

- Home and Environment Safety Check (2 hours total)
- Base Equipment Package (5 hours total)
- Base Home Modification Package (5 hours total)
- Complex Equipment Package (6 hours total)
- All In One Equipment & Home Modification Package (7 hours total)
- Powered Mobility Device Prescription Package (8 hours total)
- Ramp Home Modification Package (8 hours total)
- Transfer Equipment Package (9 hours total)

The hours of selected packages are pre-approved

Other

Reason for referral:

Podiatry

- General Foot Care
- Ingrown Nails
- Corns, Callus or Pressure Area
- Footwear Assessment

Physiotherapy

Physiotherapy Frequency (assumed pre-approved)

- Twice weekly Once weekly Fortnightly

Reason for referral:

Speech Pathology

- Mealtime Assessment Plan
- Swallow/Eating/ Drinking Support
- Communication Support

Dietetics

- Dietary assessment
- Meal planning
- Low or change to appetite
- Weight management
- Nutrition support (oral supplements and enteral feeding)
- Chronic health management

Areas of Concern

Customer Goal

Medical History and Other Information

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