In-Home Allied Health Referral Form

Plena Healthcare

136 033 community@plenahealthcare.com.au **Date of referral:** _____

Consumer Details

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

Phone Number: _____

Email Address: _____

Consumer Address: ☐ Home ☐ Facility

_____

Gender:

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

☐ Prefer not to answer

Preferred Booking Contact:

☐ Phone ☐ Email ☐ Contact via NOK ☐ Contact via Care Partner

Next Of Kin Contact Details / Alternative Contact Person

Name: _____ **Relationship:** _____

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

Referrer Details

Name: _____ **Email Address:** _____

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

Phone Number: _____

Funding Type:

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

Other (please specify): _____

Preferred Appointment Type

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

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

Referral Details

☐ Occupational Therapy

Click here to view our brochure

Package options:

☐ **Low-Complexity AT Assessment Service** *(1 hour over the phone)*

Please select the relevant AT assessment:

- ☐ *Personal Alarm*
- ☐ *Medication, Memory and Routine Aids*
- ☐ *Arthritis, Grip and Daily Living Aids*

This service is suitable for simple, low-complexity support at home (AT-HM items).

☐ **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:

☐ 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 nutrition)

☐ Chronic health management

☐ Podiatry

☐ General Foot Care

☐ Ingrown Nails

☐ Corns, Callus or Pressure Area

☐ Footwear Assessment

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.