MND Queensland OT Referral/Intake Form

ALL sections of the referral form must be completed

1. CLIENT DETAILS

Surname:	Given name(s):
Address:	
Date of Birth:	Phone:
Email:	Preferred Language:
Living arrangements: Alone Partner/ family Other (please specify)	
Who is the primary contact? (Next of Kin/Carer/Guardian) Name: Phone: Relationship:	
Preferred form of contact/correspondence: □ Phone □ SMS □ Email □ Post □ Other contact:_____	
Funding in Place: NDIS funded My Aged Care Funding Self funded	

2. REFERRER DETAILS

Check this box if you are referring yourself □

Name: Organisation:
Phone: Email:
Role: Support Coordinator Case Manager Allied Health Family member
Other _____

3. MEDICAL DETAILS

Date of Diagnosis: _____
Phenotype (if known):
ALS PBP (Progressive bulbar palsy) PMA (Progressive muscular atrophy)
PLS (Primary lateral sclerosis)
Presenting Problems:
Other medical issues:
Does the client have any supports/services in place?
GP contact details:
Name: Phone:
Address: Email:

4. SAFETY ISSUES (for the safety of our staff, it is <u>mandatory</u> this section is completed in full)

Does anyone at this property exhibit flu like symptoms, been overseas in the last month, or been in contact with anyone with the above and/or who has been diagnosed with COVID-19?	Y N
Is there a history of drug or alcohol misuse at the property?	Y N
Is anyone at the client's property known to be aggressive or violent?	Y N
Are you aware of there being firearms at the property?	Y N
Are you aware of any occupant having an infectious disease (i.e. chicken pox/ shingles/ gastro, etc.)?	Y N
Are you aware of any risks related to pets or animals on the premises?	Y N
Does anyone smoke in the home?	Y N
Is there adequate parking for staff when conducting a home visit?	Y N
Are there any other factors we should be aware of visiting this client at home on our own? If YES, please describe:	Y N

5. REASON FOR REFERRAL (Indicative length of service)

Home Assessment (initial) (2hrs)	Carer support/education (2hr)
NDIS Pre-Planning/Access Report) (2 hrs)	Equipment prescription (AT) (10hrs)
Home Modifications (20hrs)	OT direct client intervention/education: (2hrs)
Functional (ADL) Assessment (10 hrs)	Other:

What would you/ your client like to achieve from this referral?

RETURN TO:

Via Email: occupationaltherapy@mndaq.org.au

Via Fax: 07 3123 6627

Via Post: MND Queensland, Occupational Therapy Service, PO Box 470, INALA QLD 4077

For OT Use Only