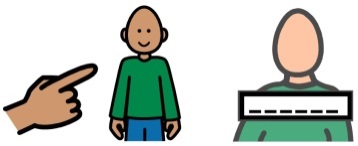
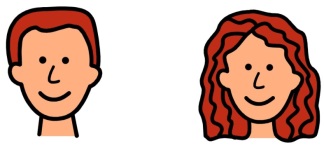
** **

**Referral Form for Occupational Therapy**

**Uniting Care - Allied Health Unit (Specialist Disability)**

**Your Details**

Your name? Male or Female? Date of birth?

|  |  |  |
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Disability?

** **

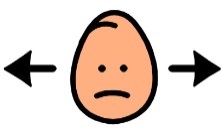
Home address? Phone number?

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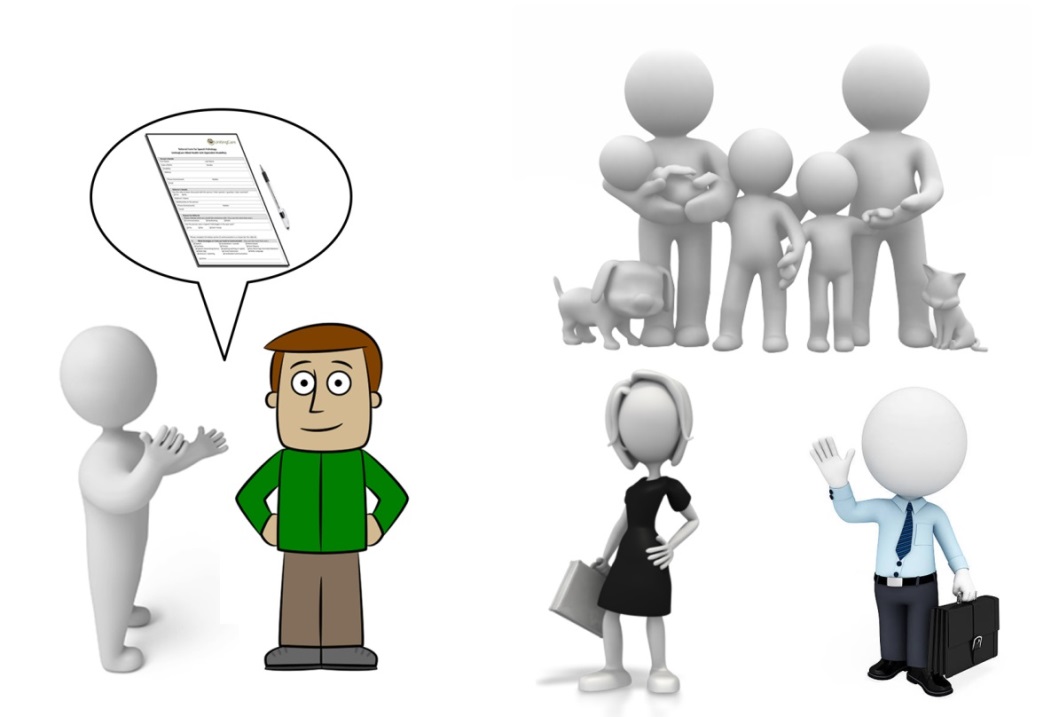
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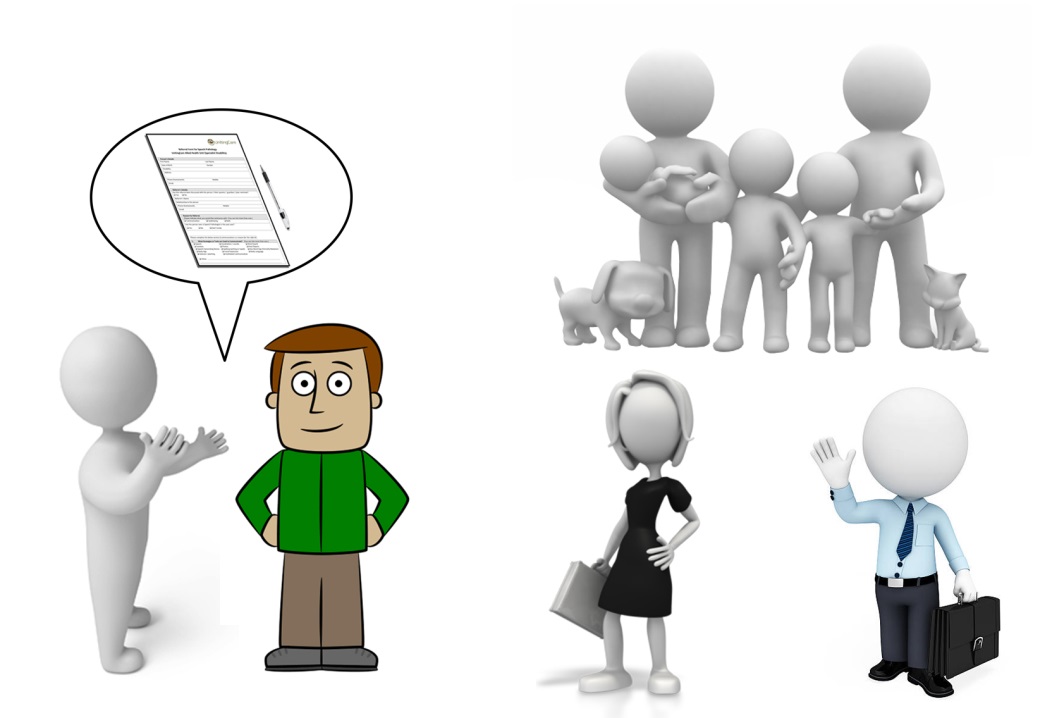


Email address?



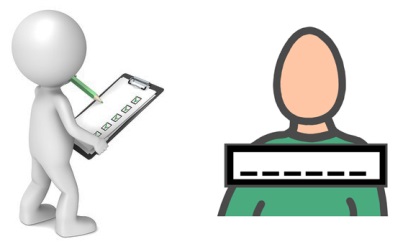
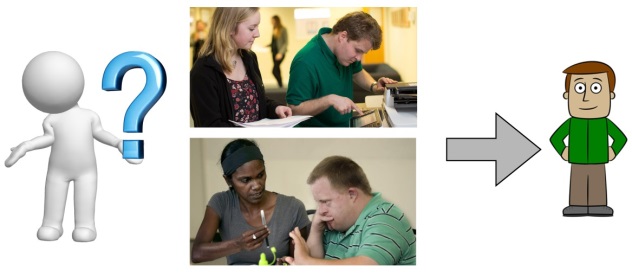
yes

Has this referral been explained to you?

****

**  **

**Referrer’s Details**

 ****

Referrer’s name? Their relationship to you?

|  |  |  |
| --- | --- | --- |
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Referrer’s phone number? Email?

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**Reason for the Referral**

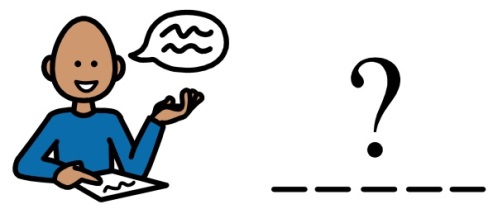
**  **

Assistive TechnologyComputer AccessFunctional Assessment

**  **

Home ModificationsSensory Processing Vehicle Modifications

****Other

****

|  |
| --- |
|  |

**Post**

**Email**

** **

*UnitingCare Allied Health Unit*

*PO Box 468*

*Annerley QLD 4103*

[*AlliedHealthUnit@uccommunity.org.au*](mailto:AlliedHealthUnit@uccommunity.org.au)

**Authorisation and Contacts**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Review and Version Control** | | | | | |
| **Version** | **Authorised By** | **Initial Approval** | **This Review Date** | **Change History** | **Next Review** |
| 1 | General Manager  Disability Services | April 2019 | 16/4/2019 | New Document | 16/4/2021 |

Signed Copy held with Continuous Improvement Disability