**Referral Form for Occupational Therapy**

**UnitingCare Allied Health Unit (Specialist Disability)**

|  |  |
| --- | --- |
| **Person’s Details** |  |
| First Name | Last Name |
| Date of Birth | Gender |
| Disability |  |
| Address | |
| Phone (home/work) | Mobile |
| Email | |

|  |  |
| --- | --- |
| **Referrer’s Details** | |
| Has this referral been discussed with the person / their parents / guardian / plan nominee? Yes No | |
| Referrer’s Name | |
| Relationship to the person | |
| Phone (home/work) | Mobile |
| Email | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason for Referral** Please indicate what you would like assistance with. (You can tick more than one.) | | |  |
| Assistive Technology | Computer Access | Functional Assessment | |
| Home Modifications | Sensory Processing | Vehicle Modifications | |
| Other: | | | |

**Please return this form via**

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

*or*

*Post: UnitingCare Allied Health Unit (Specialist Disability)*

*PO Box 468*

*Annerley QLD 4103*

**Authorisation and Contacts**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Review and Version Control** | | | | | |
| **Version** | **Authorised By** | **Initial Approval Date** | **This Review Date** | **Change History and Superseded Documents** | **Next Review Date** |
| 1 | Manager DLU | 1/2/19 | 1/2/19 | New document | 1/2/2021 |

Signed Copy held with Specialist Disability Policy and Improvement Coordinator.