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| **Funded by Home Care Package** |
| **Referral Instructions** | **Please complete all fields on this form. Then email to the appropriate intake email address depending on client’s location:** **Email to:** **Hobsons.Intake@ipchealth.com.au**for Altona Meadows Clinic**or** **Brimbank.Intake@ipchealth.com.au**for Deer Park, St Albans, and Sunshine Clinics**or** **Wyndham.Intake@ipchealth.com.au** for Hoppers Crossing and Wyndham Vale Clinics |

For services funded by Medicare or NDIS, please use other form

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| **Client Details** | Name | Name |
| Date of Birth | Date of birth |
| Address | Address |
| Phone | Phone |
| Email | Email address |
| Aboriginal or Torres Strait Islander | [ ]  Yes, Aboriginal[ ]  Yes, Torres Strait Islander[ ]  Yes, Aboriginal & Torres Strait Islander[ ]  No[ ]  not sure[ ]  decline to provide this information |
| Refugee or Asylum Seeker | [ ]  Yes [ ]  No |
| Pronouns (optional) | Pronouns |
| Gender Identity (optional) | Gender identity |
| Preferred languageProvide details if language other than English | LanguageIPC Health is unable to provide interpreters for these services.Confirm client will provide interpreter: [ ]  Yes  |
| **Guardian/ Carer/ Representative Details** **(if not applicable, please leave blank)** | Name | Name |
| Relationship to Client | Relationship |
| Address | Address |
| Phone | Phone |
| Email | Email address |
| **Client Medical History** | Relevant Medical History |
| **Reason For Referral**  | Reason for referral |

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| **Referring to Services**Please select the service, type of request, and location. If the service type you need is not listed, please contact Intake via the provided emails. | [ ]  **Occupational Therapy (Adults)** |  |
| [ ]  Home Assessment & Modifications[ ]  Falls Prevention[ ]  Equipment Prescription[ ]  Passenger Vehicle Modification | [ ]  Onsite (clinic) service [ ]  At Home service(home visit)  |
| [ ]  **Exercise Physiology (11 years and older)** |
| [ ]  Exercise Prescription[ ]  Lifestyle Advice[ ]  Assessment for education group[ ]  Education | [ ]  Onsite (clinic) service [ ]  At Home service(home visit)  |
| [ ]  **Physiotherapy (6 years and older)** |
| [ ]  Falls & Balance Assessment[ ]  Mobility Aid Prescription[ ]  Mobility Assessment [ ]  Pain Management | [ ]  Onsite (clinic) service [ ]  At Home service(home visit)  |
| [ ]  **Dietetics** |
| [ ]  Nutritional assessment[ ]  Dietary support | [ ]  Onsite (clinic) service [ ]  At Home service(home visit)  |
| [ ]  **Diabetes Education (Adults)** |
| [ ]  Diabetes Education | [ ]  Onsite (clinic) service  |
| [ ]  **Podiatry** |
| [ ]  Foot care assessment[ ]  Non-active wound management[ ]  Nail & skin care[ ]  Footware advice | [ ]  Onsite (clinic) service  |
| **Preferred Location** | For onsite services please advise your preferred location |
| [ ]  Deer Park[ ]  St Albans[ ]  Sunshine | [ ]  Altona Meadows[ ]  Hoppers Crossing[ ]  Wyndham Vale |
| **Additional Information**(ie: other services in place, requested number of sessions)Eg: 3 x OT, 1 x Physio | Additional information |

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| **Home Care Package Details** |
| **HCP Package** | Home Care Package Level | [ ]  Level 2 [ ]  Level 3 [ ]  Level 4 |
| **HCP Case Manager:** | Name | Name |
| Role | Role |
| Organisation/Company | Company name |
| Phone | Phone |
| Email | Email address |
| **Invoices** | Email address for invoices | Email address for invoices |
| **Documents** | Please provide required supporting documentation | [ ]  any relevant assessment reports or progress notes (if available) |

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| **Referrer** | Name | Name |
| Organisation/Company | Company name |
| Phone | Phone |
| Email | Email address |
| Fax | Fax number |
| Signature | Sign here |
| Date | Date |

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| **Office Use** | IPC Office Use Only | Offsite Visit Risk Ax completed [ ] Service agreement sent [ ] Referral loaded to EHR/Nookal [ ]  |