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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**](mailto:Hobsons.Intake@ipchealth.com.au)for Altona Meadows Clinic  **or** [**Brimbank.Intake@ipchealth.com.au**](mailto:Brimbank.Intake@ipchealth.com.au)for Deer Park, St Albans, and Sunshine Clinics  **or** [**Wyndham.Intake@ipchealth.com.au**](mailto: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 language  Provide details if language other than English | Language  IPC 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 |