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| **Funded by Medicare (Chronic Disease Management / Team Care Arrangement)***Support is not available for Occupational Therapy and Dietetics* |

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| **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 Home Care Package or NDIS, please use other form**

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| \* Legal sex (legal gender) is required for Medicare Card verfication and Medicare claiming |
| **Client Details** | Name | Name |
| Date of Birth | Date of birth |
| Is client 16 years or under | [ ]  Yes For children aged 16 years or under, must also provide Guardian/Parent information for the person who is listed as position 1 on the child’s Medicare card. This is because the Medicare claim is submitted against guardian on behalf of the client.[ ]  No |
| 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 |
| Legal sex (mandatory)\* | Legal gender |
| 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  |

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| **Client Age Check** | Is client 16 years or under | [ ]  Yes For children aged 16 years or under, must also provide Guardian/Parent information for the person who is listed as position 1 on the child’s Medicare card. This is because the Medicare claim is submitted against guardian on behalf of the client.[ ]  No |
| **Guardian/ Parent/ Carer/ Representative Details** **Mandatory for clients who are aged 16 years and under.****(if not applicable, please leave blank)** | Name | Name |
| Relationship to Client | Relationship |
| Legal sex\* | Legal gender |
| Address | Address |
| Phone | Phone |
| Email | Email address |
| **Documents** | Please provide required supporting documentation | [ ]  CDMP Allied Health Referral[ ]  Team Care Arrangement (TCA) |
| **Client Medical History** | Relevant Medical History |
| **Reason For Referral**  | Reason for referral |
| **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. | [ ]  **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)  |
| [ ]  **Diabetes Education (Adults)** |
| [ ]  Diabetes Education | [ ]  Onsite (clinic) service  |

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| **Referring to Services continued** | [ ]  **Podiatry** |
| [ ]  Foot care assessment[ ]  Non-active wound management[ ]  Nail & skin care[ ]  Footware advice | [ ]  Onsite (clinic) service  |
| **Not available for Occupational Therapy or Dietetics** |
| **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 |
| **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 [ ]  |