Referral Form

activeedge PHYSIOTHERAPY

email - reception@active-edge-physio.com.au | website - active-edge-physio.com.au | phone - 03 8609 1019

We welcome your referral. Please download and save our referral form, fill out your details and email the completed form to reception@active-edge-physio.com.au. We will be in touch shortly

Date ☐☐ / ☐☐ / ☐☐☐☐

Referrer Details
(note: if referring yourself or a family member, please also complete this section)

Name | **Phone** | **Postcode**

Organisation | **Email**

Address | **Role**

Client Details

First Name | **Last Name**

Gender | **Date of Birth** ☐☐ / ☐☐ / ☐☐☐☐

Phone | **Email**

Address

Housing ☐ Own Home ☐ Aged Care Facility ☐ Rental Property ☐ Supported Accommodation

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Diagnosis

Funding Source
(please select which funding arrangement best describes your situation)

☐ NDIS ☐ My Aged Care ☐ Individual Support Package

☐ Chronic Disease Management
(A Referral Form for Allied Health Services under Medicare is required from your GP)

☐ TAC ☐ WorkCover ☐ Private Health Insurer **Fund**

☐ Privately Funded ☐ Other **Policy Number**

NDIS

To assist with planning to reach the client's goals, please email a copy of the NDIS plan to reception@active-edge-physio.com.au

Participant Number | **Plan Dates: From** ___ / ___ / ___

Number of hours to attribute to physio (if known) | **Plan Dates: To** ___ / ___ / ___

Support Coordinator Details
(if different from referrer details)

Name | **Email**

Phone

Payment Management

☐ NDIS Managed ☐ Plan Managed ☐ Nominee Managed ☐ Self Managed

Plan Manager Details
(if a Plan Manager is responsible for paying invoices on the Client's behalf)

Agency / Name

Phone

Email

WorkCover / TAC

Claim Number | **Date of Injury** ___ / ___ / ___

Case Manager

Name | **Email**

Phone

Individual Support Package

Aged Care Package

Provider | **Email**

Phone

Chronic Disease Management
(A Referral Form for Allied Health Services under Medicare is required from your GP)

Medicare number:

Privately Funded

Private health Insurance fund (if applicable)

Member number

Other

Details:

Who will authorise documents and payments?

Who will authorise documents

☐ Client ☐ Nominee

Who will authorise payments

☐ Client ☐ Nominee

Nominee Details

Name

Phone

Email

Postcode

Address

Nominee Details

Name

Phone

Email

Postcode

Address

☐ Both nominee details are the same for authorising documents and payments

Appointment Contact

Who should we contact regarding appointments?

☐ Client ☐ Nominee

Contact for Appointments
(if a Nominee is to be contacted on the Client's behalf)

Name

Relationship

Phone

Email

Emergency Contact

Who should we contact in the case of an emergency?

☐ Appointment Contact ☐ Nominee

Name _____ **Phone** _____

Relationship _____ **Email** _____

GP Details

Name _____ **Clinic** _____

Phone _____

Can we contact your GP to better understand your medical history?

☐ Yes ☐ No

Allergies / Medical Action Plans

Please outline any known allergies / medical action plans as applicable, email full details to reception@active-edge-physio.com.au

Other Allied Health therapists

Details

Day Placement / School Details

Name of Centre / School _____ **Phone** _____

Contact person _____

Days/times in attendance _____

Cultural Background (please complete if applicable)

☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally & Linguistically Diverse ☐ Other

Primary languages spoken

Interpreter required? ☐ No ☐ Yes

Other Information (please tick)

If the client is verbal, do they speak in:

☐ Single Words ☐ Sentences ☐ Other:

If the client is nonverbal do they use:

☐ Gesture ☐ Facial expressions ☐ Sign ☐ Communication aid

☐ Other:

Does the client display any behaviours of concern or have a history of violence?

☐ No ☐ Yes (please detail below)

Are there any active court orders pertaining to this client?

☐ No ☐ Yes (please detail below)

Does the client have a history of mental illness?

☐ No ☐ Yes (please detail below)

Are there any potential issues for staff visiting?

☐ None ☐ Alcohol / drug use ☐ Pets ☐ Hoarding

☐ Firearms ☐ Other:

How does the client get around their home?

☐ Walking independently ☐ Walking with assistance ☐ Stand transfers only

☐ Power wheelchair ☐ Manual wheelchair

Anything else we should know?

What are your physio goals?

Appointment preferences
Client Availability for Appointments

Are there any restrictions or preferences?

How did you learn about Active Edge Physio?

- ☐ Support Coordinator
- ☐ Hospital
- ☐ Doctor
- ☐ Other Therapy Service
- ☐ Friend / Family
- ☐ Social Media
- ☐ Internet
- ☐ Brochure
- ☐ Community Event
- ☐ Signage
- ☐ Expo
- ☐ Other:

Please save this document and send it, along with any other relevant information regarding the client's medical condition, recent hospital admission/discharge, allied health or other medical reports, and physiotherapy goals, to **reception@active-edge-physio.com.au**

The information you submit in this Referral Form will be treated in accordance with our Privacy Policy available at **https://active-edge-physio.com.au/privacy-policy/**