TurnerTherapy

Client Referral Form

Occupational Therapy Services

Client Name:

First:

Last:

DOB and AGE:

Client Contact (if applicable):

Number:

Email:

Full Client Address (please include postcode):

Parent/Guardian (if applicable):

Name:

Email:

Number:

Support Co-ordinator (if applicable):

Name:

Email:

Number:

OT Sessions (please tick or highlight):

- ☐ Ongoing Therapy
- ☐ Assessments
- ☐ Report (NDIS review/application, SIL/SDA, FCA)
- ☐ Therapy Plan
- ☐ Home modifications/equipment

Funding Type:

- ☐ Privately funded
- ☐ NDIS funded
- ☐ Medicare funded
- ☐ Mixed

Frequency of Sessions:

- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ When needed

Location of therapy:

- ☐ Client Home
- ☐ In community (coffee shop, SC office, Park)
- ☐ Education (school, childcare)
- ☐ Mix of locations

Please note we are a community practice, we do not have a clinical office.

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Diagnosis:

- ☐ Autism Spectrum Disorder (ASD)
- ☐ Attention-Deficit/ Hyperactivity Disorder (ADHD)
- ☐ Oppositional Defiance Disorder (ODD)
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Sensory Processing Disorder (SPD)
- ☐ Speech difficulties (receptive/expressive/articulation/social)
- ☐ Mental health Condition (Depression, Anxiety, Bipolar, PTSD, Schizophrenia, Eating Disorder)
- ☐ Cognitive difficulties (learning disorder, cognitive disorder, low IQ)
- ☐ Neurological Disability (ABI, TBI)
- ☐ Functional Condition (MS, CP, Blindness, Spinal Cord Injury etc.)
- ☐ Undiagnosed
- ☐ Other

Therapy Goals:

- ☐ Becoming more independent
- ☐ Improving self-care skills
- ☐ Improving domestic household tasks
- ☐ Improving social skills
- ☐ Improving academically
- ☐ Improving household
- ☐ Improving equipment/ assistive technology
- ☐ Unsure
- ☐ Other

Additional Comments: