Positive Step
Occupational Therapy To You

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Referral Form

Home Visit Priority: ☐ **Urgent (1-2 days)** ☐ **ASAP (2-4 days)** ☐ **When convenient (4+days)**

Name: **Date of Birth:**
Address:

Telephone Number:

Contact person to arrange home visit: ☐ **Client** ☐ **Other** ________________________

Funding source for assessment: ____

Reason for referral:
☐ **Home assessment** ☐ **Falls Prevention**
☐ **Rehabilitation** ☐ **Other** ____

Presenting complaint/ relevant medical history:

Social History:

Risks for home visiting staff ☐ **Yes** ☐ **No** ____
(Please consider pets, infection risk, physical threat, behavioural problems, environmental factors)

Name and contact details of person referring:

Please print this form, complete it and scan to referrals@positivestep.com.au or fax to 08 9341 7300