Regional Allied Health Services Referral Form for –
Restorative Care Pathway (RCP)
Support At Home (SAH)
Commonwealth Home Support Program (CHSP)

1. SAH / RCP / CHSP CLIENT DETAILS:

First Name:	Last Name:
Date of Birth:	Phone Number/s:
Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other:	Email:
Street Address: Suburb: State: QLD Postcode:	
Living Arrangement: ☐ Alone ☐ Family/Partner ☐ Supported Accommodation ☐ Other	
Identifies as Aboriginal or Torres Strait Islander: ☐ Yes ☐ No ☐ Prefer not to say	
Alternative Contact (i.e Family member, friend, neighbour) Name: Phone: Relationship: Email:	
Type of Client: SAH (please select Level): ☐ Level 1: Entry-Level Support ☐ Level 2: Low Support Needs ☐ Level 3: Intermediate Support Needs ☐ Level 4: Moderate Support Needs ☐ Level 5: Moderate-to-High Support ☐ Level 6: High Support Needs ☐ Level 7: Very High Support Needs	

☐ Level 8: Comprehensive Care Needs

☐ Commonwealth Home Support Program (CHSP)

☐ Restorative Care Pathway (RCP)

2. REFERRER DETAILS (*please include your name, your role organisation name if a provider, phone and email)*:

Your Name:
Your Role:
The Company you work for (if applicable):
Your Phone Number:
Your Email:

3. BACKGROUND

(Please provide background information about the client, medical conditions, current situation)

Please provide background information about the client, medical conditions, current situation:

Please forward a copy of the client's most recent My Aged Care Support Plan, this provides us with the client's Good Equipment and Assistive Technology (GEAT) code (if they have one) and their medical and social background information. Also, if available, a Medical Summary from the clients GP.

☐ My Aged Care Support Plan Attached with this referral

☐ GP Medical Summary

What would you or your client like to achieve from this referral??

☐ Full Home Assessment *(The OT will complete an assessment in the client's home and provide recommendations for any necessary home modifications and/or equipment to support function in the home and community, please always select this option for CHSP and RCP referrals).*

Please provide details with what the client is experiencing difficulties with:

☐ Equipment Only - **Please provide details with what the client is experiencing difficulties with.**	
☐ Home Modifications **Please provide details with what the client is experiencing difficulties with.**	

4. SAFETY

Are you aware of any occupant at clients home having an infectious disease? (i.e. covid chicken pox / shingles / gastro, etc.) If Yes – please advise:	☐ Y ☐ N
Does the client have any pets at their premises? Details:	☐ Y ☐ N
Are there any other factors we should be aware of when going to the client's home? If Yes, please describe:	☐ Y ☐ N

5. PAYMENT OF ACCOUNT / INVOICES

Who is responsible for paying the account for Occupational Therapy Services: Organisation/funding body name: Organisation/funding body address: Phone: Email:

6. TO COMPLETE THIS REFERRAL FORM

Please state your full name and date this referral and return via email the completed form to:

Email: RAHS@outlook.com.au

Your Full Name:

Date Completed: