



AGED CARE REFERRAL FORM

Please email this form, along with any supporting documents or reports to admin@wellnessembodiedcairns.com

CLIENT DETAILS

First Name: _____
Last Name: _____
DOB: _____
Phone No: _____
Email Address: _____
Home Address: _____

CLIENT REPRESENTATIVE OR LEGAL GUARDIAN

First Name: _____
Last Name: _____
Phone No: _____
Email Address: _____
Home Address: _____
Relationship to Client: _____

PREFERRED CONTACT INFORMATION

Contact for Appointments

Name: _____
Phone: _____

WHO IS FILLING OUT THIS FORM?

Name: _____
Phone: _____ Email: _____

FUNDING DETAILS

Aged Care Fund: _____
Invoices email address: _____ Phone: _____
Case Manager name: _____
Phone: _____
What funding classification do you have? *(please ensure it includes Allied Health)* - _____

Medical Diagnosis / Presenting Conditions:

Goals:

Mobility:

☐ Cannot walk up stairs ☐ Wheelchair user ☐ Requires assistance to walk

What services have you been approved for?

- ☐ Physiotherapy
☐ Occupational Therapy
☐ Remedial Massage
☐ Osteopathy
☐ Hydrotherapy with a Physiotherapist
☐ Assistive Technology (AT) Assessment by an Occupational Therapist
☐ Home Modifications Assessment by an Occupational Therapist
☐ Other: _____

For Assistive Technology and Home Modification assessments:

What would you like to be assessed for / what outcome would you like? _____

Has your case manager confirmed you are eligible for this assessment and services? _____

Is the requested service/s: ☐ In-Clinic ☐ Home Visit / Residential Aged Care visit ☐ Hydrotherapy

COMPLETE IF HOME VISIT IS REQUESTED:

1. Living Arrangements: ☐ Alone ☐ Shared ☐ Supported ☐ With Family

2. Will other people be present when the therapist visits? If yes, who? ☐ Yes ☐ No — Details:

3. Is there a history of concerning, aggressive, or challenging behaviours with the client? ☐ YES ☐ NO

4. Is there anyone living at or regularly attending the property who may be violent, threatening, aggressive or intimidating? ☐ Yes ☐ No

5. Has anyone at the property previously threatened, assaulted or behaved aggressively towards healthcare workers? ☐ Yes ☐ No

6. Are there any concerns about a person's behaviour due to alcohol, drugs, mental health, cognitive impairment or other factors? ☐ Yes ☐ No

7. Weapons or dangerous items kept at the property? ☐ Yes ☐ No

8. Is there reliable phone/mobile reception at the property? ☐ Yes ☐ No

9. Are there any weapons or other dangerous items kept at the property that may pose a safety concern?

☐Yes ☐No

10. Is there safe and legal parking available close to the property? ☐Yes ☐No

11. Are there any access issues onto the property? (Eg: pets, side/rear entrances) ☐Yes ☐No

12. Is the pathway/entrance to the property well lit and reasonably safe? ☐Yes ☐No

13. Is the client, or anyone on the premises, a smoker? ☐Yes ☐No — Details: _____

14. Is there anything else about the person, household, property or surrounding area that could affect the safety of a physiotherapist attending this home? ☐Yes ☐No

WELLNESS EMBODIED TO FILL OUT:

SAFETY RISK IDENTIFIED:

☐No known concerns

☐Minor concerns — Precautions required

☐Significant concerns — Manager / Supervisor review required

☐Home visit NOT considered safe without additional controls