OT Intake form

Inclusion Criteria	Exclusion Criteria
• Paediatric Clients, aged 2-17 years of age • Clients experiencing functional difficulties that negatively impact their participation in everyday life • Basic (Level 1) and Standard (Level 2) Assistive Technology. • Functional Assessments if NDIS has requested, or Allied Health Professional (Speech etc.) deems client to need more funding. • Sensory assessment and recommendations if there are ongoing sessions.	• Behaviour management referrals with complex mental health or behaviour difficulties, without an actively involved lead mental health clinician and no functional difficulties are outlined. • Toileting referrals as the sole concern. • Physical disabilities; Cerebral palsy, Pigeon toed and Gait issues - **Contact Physio or specialised OT.** • Complex Assistive Technology and Home Modification (Level 3 and 4) solutions, such as ramps and structural changes to building. • Hand Therapy and Splinting referrals. • Driving Assessments. • Equipment prescriptions (Wheelchairs). • Developing Behaviour Support Plans **- Refer to Behaviour Support Practitioner.** • Accessing services using "Better Access to Mental Health Plan". • No functional goals identified.

Please understand that our OT's do not work with the presentations in the exclusion criteria above. Please tick the box below to confirm your understanding of exclusion criteria:
Yes, I have read and understand the exclusion and inclusion criteria ☐ ***Please see OT Australia's "find an OT" page for specialisations:*** **https://otaus.com.au/find-an-ot**

Please complete as much information as possible and send to info@desilvakc.com			
Date of Completion:		**Your Name:**	

Client's Details			
Full Name		**Date of Birth**	
Address (incl. Postcode)			
Gender Identity		**Cultural Identity**	
Preferred Language		**Interpreter Required?**	
Educational Setting *(School, Childcare, Kinder)*			
Health Conditions *(diagnoses, medications)*			

Preferred Contact Person Detail	
Contact Name	
Relationship Type	

Email Address	
Phone Number	

Funding Details			
Funding Type *(Please tick one)*	**NDIS** ☐	**Medicare** ☐	**Private** ☐
NDIS Number ***(if applicable)***		**How are the NDIS Funds managed?**	
		Plan Manager Name ***(if applicable)***	
Has the NDIS Plan or screenshot of goals and allocated funding been attached with referral form?			

Provision: Services Sought (Pick one, both or skip if unsure)			
☐ Assessment *(Assessing what is currently occurring for the client regarding the areas of concern)*		☐ Intervention (*Implementing strategies with the client to address areas of concern)*	
Type of Assessment ***(if known)***		**Preferred Session Frequency** *(Please tick one)*	**Monthly** ☐ **Fortnightly** ☐ **Weekly** ☐
Type of Report ***(if required)***		**Other Frequency**	
Preferred day/s of the week: (Mon-Sat)		**Preferred time slot/s:** (9-5:30pm)	

Reason for Referral/Summary of Concerns: *(Please provide as much detail as possible)*

Are there further concerns with participation within any of the below activities

☐ Support with your child's communication skills including play, speech, language, literacy and social communication. (If yes, contact us on 8418 8544 for a speech pathology referral)

☐ Dressing	☐ Sleep	☐ Toileting	☐ Leisure	☐ Accessing home and/or community
☐ Self-care and personal hygiene	☐ Mealtimes	☐ Household Tasks	☐ Education	☐ Assistive Technology

Referrer Details			
Referral Source *(internal or external referral)*		**Referral Date**	
Name			
Agency/Organisation			
Email			
Contact Number			

Any additional comments

How did you hear about De Silva Kids Clinic? *(Word of Mouth, Support Co-ordinator, Google, Social Media, GP, Allied Health Practitioner)*
☐Word of Mouth ☐Google ☐Social Media ☐Our website ☐GP ☐Other Allied Health Practitioner ☐Support Co-ordinator ☐Other:

FOR OFFICE USE ONLY			
Date Received		**Processed**	
Contacted		**Service Agreement Sent**	