TeleHealth Allied Health Referral Form

IN HOME

	Name of referrer		Date of request	
	Company (if applicable)		Referrer contact no.	
	Referrer email address		Relationship to client	
	Name of client		Client date of birth	
	Address of client		My aged care no.	
	Email address *to use for online consult*			
	Medical history ☐ Attached *(If not, please provide details)*			
	Reason for referral & Client notes			

SERVICES REQUIRED

PLEASE NOTE:
The scheduled visit will only be for the requested type of service

☐ TeleHealth ☐ TeleConnect (therapist plus AHA visit)

Discipline (tick which apply)	Appointment preferences (Multiple)
☐ Dietitian ☐ Speech Pathologist ☐ Occupational Therapist ☐ Physiotherapist ☐ Exercise Physiologist ☐ Psychologist	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

TECH INFO

Device used to access online consiltation has

☐ Camera capabilities ☐ Audio capabilities ☐ Only telephone access
☐ Internet access ☐ Will onsite support be required for technology during visit?

HOME

Home safety checklist
Only required for TeleConnect

☐ **COMPLETED HOME SAFETY CHECKLIST HAS BEEN ATTACHED**
(please ensure home safety checklist is attached)

CONTACT

	Full Name	Contact no.	Relationship to client
Primary Contact *Details to be used to organise appointments etc.*			
Secondary Contact *Will only be contact if primary contact unavailable*			

GP

GP name		GP Contact no.	
GP email			

FUNDING

Funding/ Package	☐ STRC	**START DATE**	**END DATE**
	☐ CHSP	☐ HCP	

SUBMIT FORM

homecare@concentric.com.au Phone: 1300 148 160