

## **TeleHealth Allied Health Referral Form**

## IN HOME

PLEASE NOTE: The scheduled visit will only be for the requested type of service       Dietitian       Monday         Occupational Therapist       Wednesday         Physiotherapist       Thursday         Psychologist       Thursday         Psychologist       Friday         Primary Contact       COMPLETED HOME SAFETY CHECKLIST HAS BEEN ATTAC (please ensure home safety checklist is attached)         Primary Contact       Full Name         Patalis to be used to organise appointments etc.       Full Name	Referrer contact no.         Relationship to client         Client date of birth         My aged care no.         alth □ TeleConnect (therapist plus AHA visit)         e (tick which apply)         Appointment preferences (Multiple)         n         Pathologist         tional Therapist         herapist         a Physiologist         Iogist         access         Will onsite support be required for technology during visit?         COMPLETED HOME SAFETY CHECKLIST HAS BEEN ATTACHED (please ensure home safety checklist is attached)         e       Contact no.         Relationship to client         GP Contact no.       Relationship to client         GP Contact no.       Relationship to client         GP Contact no.       Relationship to client
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       My aged care no.         Medical history       Attached (If not, please provide details)         Reason for referral & Client notes       Image: Client consult         PLEASE NOTE:: The scheduled visit will only be for the requested type of service       Image: Client consult consult         Discipline (tick which apply)       Appointment preferences (M Discipline (tick which apply)         Pyeaday       Discipline (tick which apply)         Pipsiotherapist       Monday         Speech Pathologist       Monday         Physiotherapist       Physiotherapist         Physiotherapist       Physiotherapist         Psychologist       Psychologist         Psychologist       Physiotherapist         Psychologist       Internet access Will onsite support be required for technology durin (please ensure home safety checklist is attached)         Primary Contact Will only required for TeleConnect I organise appointments etc.       Secondary Contact Secondary Contact         Primary Contact Will only be contact If primary contact unavailable       Full Name       Contact no.       Relationship         OfP name       GP name       GP Contact n	Relationship to client         Client date of birth         My aged care no.         Image: Start Date         Relationship to client         My aged care no.         Image: Start Date         Relationship to client         My aged care no.         Image: Start Date         Relationship to client         My aged care no.         Image: Start Date         Relationship to client         Image: Start Date         Relationship to client         Image: Start Date
Name of client       Client date of birth         Address of client       My aged care no.         Email address to use for online consult       My aged care no.         Medical history       Attached (ff not, please provide details)         Reason for referral & Client notes       TeleHealth □ TeleConnect (therapist plus AHA visit)         Discipline (tick which apply)       Appointment preferences (M □ Discipline (tick which apply)         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 (M □ Discipline (tick which apply)         PLEASE NOTE: The scheduled visit will only be for the requested type of service       □ Camera capabilities □ Discipline (tick which apply)         Physiotherapist Physiotherapist □ Physiotherapist □ Physiotherapist □ Physiotherapist □ Physiotherapist □ Thursday       □ Tuesday         OF       Device used to access □ Internet access □ Will onsite support be required for technology durin (please ensure home safety checklist is ottached)         Primary Contact Detaits to b used to organise appointments etc.       Full Name       Contact no.       Relationship         Secondary Contact Will only be contact if primary contact unavailable       Full Name       Contact no.       Relationship         OF name       GP name       GP Contact no.       Relationship       Image <th>Client date of birth         My aged care no.         Alth         TeleConnect (therapist plus AHA visit)         a (tick which apply)         Appointment preferences (Multiple)         n         Pathologist         Itional Therapist         herapist         e Physiologist         logist         access         Will onsite support be required for technology during visit?         COMPLETED HOME SAFETY CHECKLIST HAS BEEN ATTACHED (please ensure home safely checklist is attached)         contact no.       Relationship to client         GP Contact no.       Relationship to client         GP Contact no.       Relationship to client</th>	Client date of birth         My aged care no.         Alth         TeleConnect (therapist plus AHA visit)         a (tick which apply)         Appointment preferences (Multiple)         n         Pathologist         Itional Therapist         herapist         e Physiologist         logist         access         Will onsite support be required for technology during visit?         COMPLETED HOME SAFETY CHECKLIST HAS BEEN ATTACHED (please ensure home safely checklist is attached)         contact no.       Relationship to client         GP Contact no.       Relationship to client         GP Contact no.       Relationship to client
Address of client       My aged care no.         Email address to use for online consult       My aged care no.         Medical history       Attached (ff not, please provide details)         Reason for referral & Client notes       TeleHealth □ TeleConnect (therapist plus AHA visit)         Discipline (tick which apply)       Appointment preferences (M □ Discipline (tick which apply)         PLEASE NOTE: The scheduled visit will only be for the requested type of service       Camera capabilities □ Audio capabilities □ Only telephone access □ Internet access □ Will onsite support be required for technology durin □ herenet access □ Will onsite support be required for technology durin (please ensure home safety checklist organise appointments etc.         Device used to access online consiltation has       Camera capabilities □ Audio capabilities □ Only telephone access □ Internet access □ Will onsite support be required for technology durin (please ensure home safety checklist is attached)         Primary Contact Will only be contact if primary contact unavailable       Full Name       Contact no.       Relationship         Primary contact Will onby contact if primary contact unavailable       Full Name       Contact no.       Relationship         Of P name       GP name       GP Contact no.       Relationship	My aged care no.         Appointment preferences (Multiple)         n       Appointment preferences (Multiple)         n       Monday         Pathologist       Tuesday         tional Therapist       Wednesday         herapist       Thursday         e Physiologist       Thursday         logist       Friday         capabilities       Audio capabilities         capabilities       Audio capabilities         capabilities       Contact no.         Relationship to client         ge       Contact no.         Relationship to client         ge       Contact no.         GP Contact no.       Relationship to client
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Funding/Package        □ STRC     START DATE     END DATE          □ CHSP         □ HCP	