

Port Hill Therapists OT Referral Form

Fax to: (03) 9749838
 Email: info@porthilltherapists.co.nz

Phone: Catherine Fink 027 221 9071
 Phone: Louise Tapper 021 0231 3482

Patient Information	
Patient Name: NHI#: ACC Claim #:	Referrer's name
DOB	GP Name
Address	Practice Address
E-mail	Phone
Phone	Fax
Brief Medical and Social History	Medications (if relevant. e.g. psycho-active/analgesic)

Reason for Referral for Occupational Therapy	
TICK	TICK
<input type="checkbox"/> Home Environment Assessment	<input type="checkbox"/> Wellness Management: healthy routines/habits e.g. exercise, sleep, eating habits, stress management etc
<input type="checkbox"/> Falls Prevention Intervention	<input type="checkbox"/> Engagement in meaningful activity/ Problem solve barriers to participation
<input type="checkbox"/> Independence and Safety training e.g.: performing daily tasks in home/community	<input type="checkbox"/> Role Transition. e.g. Retirement, caregiver, dependent, loss of drivers license
<input type="checkbox"/> Community Participation/Socialisation	<input type="checkbox"/> Work/Productivity
<input type="checkbox"/> Education in strategies: fatigue/pain, stress/anxiety, managing disability etc	<input type="checkbox"/> Other
Other Relevant Info.	
Expected Outcome:	

Funding Source (please circle applicable source)			
<input type="checkbox"/> Patient Privately Self Pays \$85 first visit and \$70 per visit thereafter	<input type="checkbox"/> Acute Demand/Care Plus/Access/Other Patient Co-pays \$20 per session	<input type="checkbox"/> Collaborative Care Programme	<input type="checkbox"/> ACC Patient Co-pays \$20 per session