General Referral Form

Independent Rehabilitation Services
239 Koornang Rd, Carnegie Vic 3163
(03) 9885 2533
referral@independent-rehab.com.au
www.independent-rehab.com.au

Our Vision is to be the primary choice for trusted quality Allied Health services in community rehabilitation and disability.

Independent Rehabilitation Services
Working Towards Your Recovery

Please complete **ALL** fields below and email to referral@independent-rehab.com.au. Referrals may be delayed if information is incomplete. If the information is not available, please write N/A.

Referral Type:
Private: ☐ TAC: ☐ VWA: ☐ Driving Ax: ☐ DVA: ☐ Other: ☐

Claim Number if applicable: _____

CLIENT DETAILS

First Name: Surname: Date of Birth:

Gender identity: Female ☐ Male ☐ Non-binary ☐ Transgender ☐
Prefer not to say ☐ Other _____

Preferred pronouns: She/her/hers ☐ He/him/his ☐ They/them/theirs ☐
Other _____ Prefer not to say ☐

Aboriginal and/or Torres Strait Islander origin Yes ☐ No ☐

Cultural background:

Main language spoken at home: Interpreter required: Yes ☐ No ☐

Address:

Own home: ☐ Private Rental: ☐ Supported Accommodation: ☐ Nursing Home: ☐
Other:

Phone Number: Mobile:

email:

Preferred method of communication
Phone: ☐ Text: ☐ Email: ☐

Primary Contact: Participant: ☐ Next of Kin: ☐ Other: ☐ _____

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Next of Kin:

First Name : Surname:

Phone Number: Home: Mobile Number:

Email Address: Relationship to Participant:

Participant Medical History:

Therapy Goals:

IRS Services requested:

☐ Physiotherapy

☐ Occupational Therapy

☐ Speech Pathology

☐ OT Driving Assessment

Preferred Days of service (between the hours of 9am and 5pm)

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any ☐

Risk Assessment:

Please detail any potential risks for our staff:

- Animals on premises ☐
- History of violence ☐
- Behaviours of concern ☐
- Weapons/firearms on premises ☐

Other:

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REFERRER DETAILS:

Referrer Name: Organisation:

Phone: Work: Mobile: Fax:

Email:

Address:

INVOICING DETAILS:

Contact: Organisation:

Phone: Fax:

Email:

SUPPORT CO-ORDINATOR/ CASE MANAGER DETAILS (if different to referrer details):

Phone: Work: Mobile: Fax:

Email:

Address:

Why did you choose IRS?

DETAILS OF EXISTING TEAM TO SEND FEEDBACK TO:

Name	Service	Contact details ie phone, email, fax
	GP	
	Paediatrician	
	Medical Specialist	
	Other	

Once complete, the intake form can be returned to: referral@independent-rehab.com.au

IRS is committed to protecting individuals' right to privacy. We comply with federal and state legislation relating to confidentiality and privacy. All personnel maintain the highest standards of professional practice and codes of conduct regarding the confidentiality of personal information.

Last updated December 2019