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| cid:image001.png@01D3466F.F8147200**Occupational Therapy**  **Referral** |

**Guidance for Referral:**

**COMMUNITY OCCUPATIONAL THERAPY**

Please complete **this** referral form for:

* Assessment for home adaptations
* Specialist seating assessments
* Moving and handling assessments, where there is no rehab need.
* Assessment for Equipment, where there is no rehab need
* *This is not an exhaustive list, if you are unsure if an assessment is required and wish to discuss prior to referral, please contact our Duty OT Service:* [*dutyOT@moray.gov.uk*](mailto:dutyOT@moray.gov.uk) *or 01343 563845*

*For Out of Area Hospital Discharge requiring equipment only –* ***please complete Out of Area Hospital OT equipment form***

Moray Council is the Data Controller for this process. Please see our Privacy Notice at [Moray Council Privacy Notices](http://www.moray.gov.uk/moray_standard/page_142831.html) for information about how the personal data provided on this form will be used.

**NHS OT/ NHS PHYSIOTHERAPY REHABILITATION SERVICES**

If you/the person you are referring requires any of the below please discuss with your GP or allocated registered professional to be referred to Occupational Therapy or Physiotherapy Rehabilitation Service

**\*Professionals only (GPs/ health professionals/SW)** – please contact [gram.moraycommunityotpt@nhs.scot](mailto:gram.moraycommunityotpt@nhs.scot)

* Intervention soon after diagnosis aiming to prevent deterioration / maintain / improve function, eg:

Strength and balance training

* Functional Rehabilitation for Cognitive and Visual Perceptual Difficulties - *diagnosed Neurological conditions only*
* Functional activities rehabilitation
* Fatigue management
* Long Term Condition management predominantly neurological and respiratory conditions where a new evaluation is required
* Advice / education / self-management skill training
* Falls Prevention, Step in the Right Direction, Pulmonary Rehabilitation
* Walking Aids and advice on mobility

**OTHER**

For **equipment repairs and collections** please contact the Joint Equipment Store on 01343 546512

**Wheelchair referrals** can be made by any registered health professional. If you/the client are being seen by District Nurse, Physiotherapist or Occupational Therapist please discuss with them before completing referral

Inappropriate or Incomplete referrals will be returned

**Please complete as many details on this form as necessary, this will help us to set the correct priority to the referral.**

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| --- | --- | --- | --- | --- |
| **Client Details** | | | | |
| **Full Name** |  | | | |
| **Full Address (include Post Code)**  **\***We accept Moray Council Tax area’s only |  | | | |
| **Telephone Number** |  | | | |
| **Email Address Client** |  | | | |
| **Date of Birth** |  | **Gender** | |  |
| **Ethnicity** |  |  | |  |
| **Does Client agree to the referral** | YES  NO  If No, please specify why:  Permission must be given by the Client unless they are unable to do so before an Assessment can go ahead. | | | |
| **Does client consent to information sharing** | YES ☐ NO ☐ If No, please specify why: | | | |
| **Power of Attorney** | YES  NO  If yes, please specify details: | | | |
| **Carefirst ID Number** |  | | | |
| **Does Client Live Alone** | YES  NO  If No, provide full names of all people living at property and their relationship to Client: | | | |
| **Name** | | **Relationship to Client** | |
|  | |  | |

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| **Referrer Details** | |
| **Name** |  |
| **Designation** |  |
| **Organisation** |  |
| **Address** |  |
| **Contact Telephone Number** |  |
| **Date** |  |

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| **Contact regarding the OT Assessment** | | | |
| **Who should be contacted regarding the Assessment** | Client  Other  If ‘other’ is chosen, please specify who should be contacted below: | | |
| **Name** | | **Relationship to Client** | **Contact Telephone Number** |
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| **GP Details** | | |
| **GP Practice Name** |  | |
| **Address** |  | |
| **Telephone Number** |  | |
|  | | |
| **Hospital Discharge Details** | | |
| **Is Client currently residing in Hospital or has recently been discharged?** | | YES  NO  If No, go to next section – ‘Referral Details’  If Yes, carry on with this section of the form. |
| **Date Client was / is due to be discharged** | |  |
| **Where will the Client be discharged to i.e. home, another hospital etc** | |  |
| **Contact details for access to property** | |  |
| **Please list any equipment / adaptations essential for discharge** | |  |

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| **Client’s Medical Condition** | |
| **Please specify the Client’s medical condition(s)** previous and present relevant conditions  \*Must be completed | Presenting medical history:  Past medical history: |
| **Is Client’s condition terminal or do they require palliative care?**  **(\*\*Professionals to answer only)** | YES  NO ☐ DON’T KNOW  If yes, has a DS1500 form been completed? YES  NO  PPS score if known: |

|  |  |
| --- | --- |
| **Referral Details**  **Please provide as much detail as possible (i.e. existing equipment, description of difficulties, etc): Please note if there is not enough information the form may be returned for further information.** \*Must be completed | |
| **Reason for Referral:**  Current Mobility Status: Independent without aids  Independent with Aids  With difficulty  Unable  **Details:**  Falls: Frequent ☐ Occasional ☐ No ☐  **Details:**  Getting on/off chair: Independent  With Difficulty  Unable  **Details:**  Getting in/out of bed: Independent  With Difficulty  Unable  **Details:**  Getting on/off toilet: Independent  With Difficulty  Unable  **Details:**  Getting in/out bath/shower: Independent  With Difficulty  Unable  **Details:**  Stair Mobility: Independent  With Difficulty  Unable  Not applicable  **Details:**  Getting in/out of property: Independent  With Difficulty  Unable  **Details:**  Difficulty with moving and handling: Yes  No  **Details:**  Other difficulties/ further information: | |
| Does property have any adaptations? YES ☐ NO ☐ DON’T KNOW ☐  If yes, provide details (type, through OT or Private?) | |
| **Has Patient been referred to, or had input with, another Service e.g. Physio, Rehab OT, Primary Care, Hospital OT, etc**  \*Must be completed | YES  NO  DON’T KNOW  If yes, please specify |
| **Formal/informal Care Provision**  \*Must be completed | YES  NO  DON’T KNOW  If yes, please specify agency, double/single and times |

**Please complete and email this form to:**

[**Access**](mailto:customer.services@aberdeenshire.gov.uk)**careteam@moray.gov.uk**