**Allied Health Service Request Form**

This form can be used to request an OT and/or PT assessment to determine equipment or home modification needs for Advanced Palliative Equipment Response (APER) or Adults with Chronic Conditions (ACC) clients. The Equipment Program will generate a referral to our contracted AHS provider for the assessment.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client Details | | | | | | | |
| Client ID       Funder:  APER  ACC Date of Request | | | | | | | |
| Phone | | | | | Date of Birth | | |
| Prefix | Last Name | | | | | First Name | | |
| Preferred Name | | | | | | Pronouns | | |
| Gender:  M  F  Non-binary  Prefer to not answer  Different term | | | | | | | |
| Email       Client Weight | | | | | | | |
| Residential Address | | | | | | | |
| Suburb | | | | | | | Postcode |
| Interpreter required  Y Primary Language        N | | | | | | | |
| Alternate contact (if applicable)Guardian Other | | | | | | | Preferred contact?  Y  N |
| Name | | Relationship | | | | | |
| Phone | | Email | | | | | |
| Referrer Details | | | | | | | |
| Name | | | Profession | | | | |
| Organisation | | | | | | | |
| Email | | | | Phone | | | |
| **Consent** | | | | | | | |
| Does client give consent for the Equipment Program to share relevant information and coordinate this assessment with our contracted AHS provider?  Y  N | | | | | | | |
| **Medical information** | | | | | | | |
| Current Relevant Medical Information (if updated since registration form completed)  **Diagnosis:**  **Prognosis:**  AKPS:       Phase:       RUG-ADL: | | | | | | | |
| Additional Information: | | | | | | | |
| **Is client currently in hospital/ hospice?**  N  Y If yes, planned discharge date: | | | | | | | |
| **Assessment Request Details** | | | | | | | |
| Discipline Requested:  OT  PT **PT must be requested Mobility Ax or Equipment**  Priority:  Urgent (1 day) Provide risk identified:  High (within 3 days)  Low (within 2 weeks)  Details of assessment needed: | | | | | | | |
| Send completed form to[**DHSEquipmentProgram@sa.gov.au**](mailto:DHSEquipmentProgram@sa.gov.au)or **fax** to **1300 295 839** | | | | | | | |