**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.

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| 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**or **fax** to **1300 295 839** |