**Mind and Body (Allied Health) Referral**

**Date: / /**

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| **Full Name:** |  | **Invoicing Details:**  W/Comp?  MAIB?  Aged Care Package  Private  DVA (D904 referral required) |  |
| **Date of Birth:** |  |
| **Clients Address:** |  |
| **Contact Details to Arrange Assessment? Client, NOK, or Service Provider?** |  | **Alternative Contact Details:** |  |
| **Alerts/Allergies:** |  | **Urgency?** |  |

If you have a preferred clinician please highlight, if referring to one or multiple supports please allocate funding available or if quote is required.

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| Item Name and Clinician Options | Rate (per hour or part thereof) | Funding Available |
| Assessment Recommendation Therapy or Training - Occupational Therapist  **Prathip Devaraj – 14 yrs and over –** Specialty area MH (Forensic)  **Ranjini Radhakrishnan – 14 yrs and over -** Specialty area MH (Rehab/Cognitive)  **Praveen Jayachandren –** Specialty area Neurological Conditions, Cognitive Rehab and Hand Therapy (including Splinting)  **Sarah Langsford (Launceston Based)** - **14 yrs and over -** Specialty area Neurodiverse and MH | $193.99 |  |
| Assessment Recommendation Intervention and/or Training – Physiotherapist  **Jayne Grubits-King – 16 yrs and over**  **Georgie Palmer (Special interest in Pelvic Health)**  **Abhishek Kumar Singh – All age group** | $193.99 |  |
| Assessment Recommendation Intervention and/or Training - Psychology  **Tracey Spencer- Lloyd, Telehealth -** Therapeutic sessions | $244.22 |  |
| Assessment Recommendation Intervention and/or Training - Speech Pathologist  **Rachael Stocks –** waitlist | $193.99 |  |
| Dietician Consultation and Diet Plan Development  **Erica Cunningham (Maternity Leave)** Focus area Children and Peg Participants | $193.99 |  |
| Assessment Recommendation and/or Training  **Continence Assessments and/or Comprehensive Nursing Assessments**  **Sophie Hill**  Minimum of 8-10 hours required for a comprehensive assessment and recommendations | $138.60 |  |

**Medical History:**

**Social/Home situation:**

**Current services (Including other Allied Health professionals):**

**Reason for referral:** (EG; Psychology formal assessment or therapeutic sessions only? OT, Activities of daily living assessment, sensory, skill building, equipment? Please provide as much information as possible)

**Consent:**

**I ………………………………… consent for this referral to be sent and for relevant reports, history and information be shared with ELPE Health.**

**Participant or Participant's representative Name: (please print)**

**Signature:** **Date: / /**

**Please provide as much detail as possible in the referral, more information will assist the clinical team to triage and assess the urgency.**

**Previous reports when consent to share has been obtained would be beneficial also.**