Reflecting Health
a functional approach

Referral instructions:

Please email completed referral form to: admin@reflectinghealth.com.au along with:

- A copy of the participant's NDIS plan* (OR an indication of the hours of service required) *one of these is required for the referral to be completed.*
- AND a completed Home Visit Risk Assessment Form.

Please note that incomplete referrals may not be processed until all relevant information has been received.

Why do we ask for the participant's NDIS plan or for the hours available?

There are a number of reasons that Reflecting Health requires this information, including:

- This information must be included in a Service Agreement. A Service Agreement must be agreed upon and signed by the participant/representative prior to the commencement of services.
- Where a participant is NDIA managed, Reflecting Health needs to place a service booking in the NDIA portal requesting that a certain amount of funding be put aside for our services for that year/plan period.
- To ensure adequate funding for services requested.
- To ensure accurate scheduling for Allied Health Professionals (ongoing appointments vs a one off assessment).
- It assists us with allocating participants to a clinician with appropriate availability.
- To ensure adequate funding for things like travel time and administration.

0429 292 022
admin@reflectinghealth.com.au
www.reflectinghealth.com.au
2/79 High St, Wodonga Vic, 3690

Referral Guidelines

In an emergency please call 000 immediately.

Please Note

Reflecting Health is not an acute/emergency health service. If you have any immediate concerns regarding the safety and wellbeing of yourself or another person please contact your GP or emergency services.

Referral Sources

Self Referral, Family/Friends Referral:

People requiring private Allied Health services are encouraged to fill out the client registration form available here.

People requiring NDIS supports are encouraged to complete the below referral form or have it completed by your Plan Manager/Support Coordinator/Family and return it to us with all relevant documentation. Reflecting Health will then be in touch to arrange an initial assessment.

Professional Referral:

Reflecting Health welcomes referrals from professionals such as GP's, NDIS Support Coordinators, LAC's, Plan Managers etc.

NOTE: Clients do not require an NDIS plan to work with Reflecting Health as we also offer private services. If you are wanting to engage private services, please complete our Private Registration Form.

New Client NDIS Registration Form

Date of referral:

Consent

KickStart Allied Health is a voluntary service for people of any age requiring Allied Health support. KickStart Allied Health can only engage with an individual if they have consented to the referral. Young People under the age of 18 or participants who are otherwise unable to provide consent, must have a parent/guardian/advocate consent to the referral before contact can be made.
Has the individual consented to the referral? Y ☐ N ☐
If the individual is under 18 years of age, has the parent/ guardian/advocate for the individual consented to the referral? Y ☐ N ☐ Please provide details of the person consenting below:

Name:	Number:

Participant Details - *Please make sure all sections are completed and legible.*

Surname:	First Name(s):
Title (Miss, Mr, Mrs etc):	DOB:
Gender: Male ☐ Female ☐ Other ☐ (please provide further information below)	
Address:	
Phone (mobile):	Phone (other):
Email:	

Emergency Contact

Name:	Phone number:
Relationship to Participant:	

Where did you hear about us?

Google ☐	Facebook ☐	Word of Mouth ☐
Other (please specify)		

Details of the Referrer ***(If not a self referral):***	
Name:	Organisation:
Email:	Phone number:
Relationship to Participant:	
NDIS Plan Information	
Please note it is not compulsory to supply a copy of the NDIS plan, however if you have not attached a copy of the plan to the referral, we will need to know the hours available on the NDIS plan to be allocated to the service you are engaging. Please include travel time and an allowance for administrative tasks and km's traveled in your estimate. Please note that referrals without this information may not be processed until we have a better idea of the needs of the participant.	
Is a copy of the NDIS plan being sent through with this referral? Y ☐ N ☐	
NDIS Number:	NDIS Plan Dates:
Self Managed ☐ Plan Managed ☐ NDIS Managed ☐	
Plan Manager ***(If applicable):***	
Name:	Organisation:
Email:	Phone number:
Support Coordinator ***(If applicable):***	
Name:	Organisation:
Email:	Phone number:
NDIS Goals ***(please complete if you are not sending a copy of the NDIS Plan)***	
Please list goals as applicable to the referral:	

Referral Information:

Who do you need to see? Physiotherapist ☐ Speech Pathologist ☐

Occupational Therapist ☐ Allied Health Assistant ☐

Please indicate the number of hours or funding you wish to allocate towards the services you are referring for (e.g 10 hours speech and 10 hours AHA).

Relevant Past History: Please include any relevant previous reports along with this referral form. Please also include information about your primary diagnosis and any other relevant medical history.

What are your expectations of KickStart Allied Health?

- Please include the intended outcome of the referral e.g Assessment and report to assist with housing etc.
- Please include some background information about the participant and their health concern, also specifically what you would like our practitioners to assist with.

Example:

"I'm requiring ongoing assistance with my speech and language skills as I have trouble forming certain sounds and words." or "I require an assessment for home modifications, specifically a ramp to be installed at the back and possibly some other modifications as recommended by the OT, as I often use a powered wheelchair to go outside the house."

Referral Information *(Continued):*

Preferred location of appointments (home, school etc): If your preferred location is not in the home, please specify with name/address of preferred location.

Is the participant currently receiving other services? (please tick all that apply)

- ☐ Occupational Therapy
- ☐ Allied Health Assistant
- ☐ Counselling
- ☐ Personal Care
- ☐ Physiotherapy
- ☐ Medical Care
- ☐ Speech Pathology
- ☐ Nursing

Please provide further details:

GP Details

Does the Participant have a regular GP? Y ☐ N ☐	
Name of GP:	Phone number:
Name and location of Clinic:	

Participant Signature	
If the referrer is unable to obtain a signature from the participant, please indicate that verbal consent has been received.	
Name:	Date:
Signature:	
Guardian/Representative Signature	
If the referrer is unable to obtain a signature from the participant's guardian/representative, please indicate that verbal consent has been received.	
Name:	Date:
Signature:	
Referrer Signature	
Name:	Date:
Signature:	

Offsite/Home visit Risk Assessment

Hazard Management details - General

Activity: Offsite/Home visit
Client Name:
Address of sessions:
Name of person conducting activity:
Date assessment conducted:

Risk Assessment Matrix

Refer to the following tables to complete the risk assessment

1. Consequence - Evaluate the consequence of a risk occurring according to the ratings in the top row		
Descriptor	**Level**	**Definition**
Insignificant	1	No injury
Minor	2	Injury/ill health requiring first aid
Moderate	3	Injury/ill health requiring medical attention
Major	4	Injury/ill health requiring hospital admission
Severe	5	Fatality

2. Likelihood - evaluate the likelihood of an incident occurring according to the ratings in the left hand column		
Descriptor	**Level**	**Definition**
Rare	1	May occur somewhere, sometime (“once in a lifetime, once in a thousand years”)
Unlikely	2	May occur somewhere over an extended period of time
Possible	3	May occur several times over a period of time
Likely	4	May be anticipated multiple times over a period of time. May occur once every few repetitions of the activity or event.
Almost Certain	5	Prone to occur regularly. It is anticipated for each repetition of the activity or event.

3. Risk Matrix - Using the matrix, calculate the level of risk by finding the intersection between the likelihood and the consequences					
Likelihood	**Consequence**				
	Insignificant	**Minor**	**Moderate**	**Major**	**Severe**
Almost certain	Medium	High	Extreme	Extreme	Extreme
Likely	Medium	Medium	High	Extreme	Extreme
Possible	Low	Medium	Medium	High	Extreme
Unlikely	Low	Low	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

4. Risk level/rating and actions	
Description of risk	**Actions**
Extreme	Notify appropriate authority (FaCS/Agency/NGO) **immediately** and cease associated activity.
High	Notify appropriate Agency/NGO/Caseworker. Corrective actions should be taken before any engagement with the client can continue.
Medium	Notify appropriate Agency/NGO/Caseworker. Corrective actions should be taken before any engagement with the client can continue.
Low	Notify appropriate Agency/NGO/Caseworker to follow up that corrective action is taken within a reasonable timeframe.

Hazard identification Checklist		
Risk of harm to others? *Violence, damage to property, past history, etc.*	Yes ☐ No ☐	If **Yes,** what?
Risk of harm to self? *Suicide, self-harm, past history, etc.*	Yes ☐ No ☐	If **Yes,** what?

Safe living environment? *House clean, others in house known to be safe, house safe, environment not likely to cause harm to clinicians, animals*	Yes ☐ No ☐	If **No,** why?
Is anyone else likely to be at home when we visit?	Yes ☐ No ☐	If **Yes,** what is the relationship to the client?
Do you or anyone else living with you smoke?	Yes ☐ No ☐	If **Yes,** please understand that we request **No smoking** during the visit.
Is anyone likely to be consuming drugs or alcohol during the visit?	Yes ☐ No ☐	If **Yes**, please be advised that the visit will not proceed.
Are there any weapons, including firearms, in the house?	Yes ☐ No ☐	If **Yes,** what are they? Are they registered? Are they locked up?
Do you have any animals?	Yes ☐ No ☐	If **Yes,** please provide details. Can they be controlled during the visit?
Is there mobile phone or text message coverage?	Yes ☐ No ☐	If **No,** what plan is in place to mitigate this?

Is the house easy to access and find?	Yes ☐ No ☐	If **No,** provide details below:
Is there anything else we need to know about before we visit?	Yes ☐ No ☐	If **Yes,** provide details below:

Risk Assessment sign off	
Office Use Only	
Proceed with home visit? ☐ Yes ☐ No	
If **Yes,** any additional conditions?	
Authorised by (name and position):	
Signature:	Date: