

Health Care Provider Referral

CLIENT INFORMATION

Name: _____ Gender: _____

D.O.B: _____ Preferred Pronoun: _____

Diagnosis: _____

Phone Number: _____ Email: _____

Address: _____

Consent YES NO

Referrer has discussed with client and they have consented to this referral

Do you identify as Aboriginal or Torres Strait Islander? YES NO

Refugee Status: _____

Languages spoken: _____ Interpreter: YES NO

Client medical summary: *Diagnosis, illnesses, health problems, communication needs etc* _____

Client's reason for referral: _____

NEXT OF KIN / CARER

Name: _____ Relationship: _____

Phone Number: _____ Email: _____

REFERRER DETAILS / PROVIDER INFORMATION / BILLING INFORMATION

Date of referral: _____ Service requested: Speech Pathology OT

Organisation: _____ Telephone: _____

Referrer name: _____ Email: _____

Funding level: _____

Person responsible for account: _____ Email address for invoices to be sent to: _____

Home Screening

For the referrer to complete

QUESTION	YES	NO	COMMENTS
Will the Therapist see your home from the street?			
Will the Therapist be able to park near your home?			
Will the Therapist be using the front door?			
Is there mobile phone coverage at your home?			
If no one answers the door, what would you like the Therapist to do?			
Will there be anyone else at home when the Therapist visits and is a second person needed?			
Are there working fire alarms?			
Is there anyone in the house with a contagious illness?			
Will there be any animals at the home and can the animals be secured during the visit?			
Are the paths and floor spaces in the house level, non-slip and free of clutter and trip hazards?			
Is the lighting / ventilation appropriate for the activities being planned?			
<p>Is there knowledge of the home situation that indicates there may be a risk to the Therapist visiting the home for example:</p> <ul style="list-style-type: none"> • All involved parties are agreeable to a home visit • Violence • Threatening behaviour (physical or verbal) • Inappropriate behaviour • Weapons • Substance abuse 			

Fee Schedule

SESSION TYPE	FEE P/ HOUR	WHAT THIS INCLUDES
Therapy Session	\$150	Assessments completed with the client and their caregivers at home regarding their current functional capacity and their home environment. Initial appointments are usually booked for 90 minutes to allow adequate time for information gathering required for the report.
Therapy Planning Time	\$150	If required, therapy planning activities for the client and caregiver discussion about strategies for home.
Non Therapy Time	\$150	Time dedicated to contacting stakeholders to progress the client's case such as (but not limited to) speaking with relevant carers and other supports to gain further information about the client, researching appropriate equipment and contacting suppliers.
Report*	\$150	60 mins of comprehensive standard functional capacity report with some recommendations for equipment, further support required or further assessments required. Quotes can be provided if possible to do so and to be discussed with the therapist. Please note that this is a price per hour fee, and time spent on reports may vary between clients, goals and recommendations.
Travel Time	\$120	<i>Travel- Individual prices may vary and are calculated per client and may differ appointment to appointment.</i> Providers can claim up to 30 minutes travel each way at the hourly rate of the relevant support item to the client e.g 10 minutes travel from where the Therapist was prior and post appointment.

*REPORTS

Comprehensive Allied Health Report

Approximately 2-3 hours

Comprehensive analysis of client's functional status, home environment, barriers and subsequent clinical recommendations with risk of non-provision.

YES

NO

Letter of Support

30 minutes +

Dependent on number of recommendations and subsequent clinical justifications. Details the barrier, functional limitation and clinical justification only in relation to the recommended equipment, intervention or home modification.

YES

NO

Please select the type of evidence or report that is required from the Therapist. This must be selected prior to the first appointment. The report will be completed within one week of the final appointment. Time spent on reports may vary depending on the reason for referral and subsequent number of recommendations. Please talk to the Therapist if you require further information.

PAYMENT

After the client appointment, Domain Health will email the nominated party an appointment invoice for payment. Our invoice terms are within 7 days of issue.

WAYS TO PAY

You can pay via:

Bank transfer

Direct debit

Online (via credit card or PayPal)

CANCELLATION OF APPOINTMENTS

All cancellations must be received 48 hours before the appointment so as to not incur a cancellation fee.

To cancel please call (03) 96961597. Late cancellations made following this time will incur 100% of the hourly fee.

If you fail to attend or cancel 3 appointments out of a block of 6 appointments, then your Therapist may discuss and review on-going appointments. This is particularly relevant for families who have secured in demand after school appointment slots.

We agree that any changes to this Agreement will be in writing, signed and dated.

HOW TO CANCEL THIS AGREEMENT

Should either party require this Agreement to end, no notice period is required. If either party seriously breaches this Agreement, then the Agreement will be ceased immediately.

WHAT TO DO IF THERE IS A PROBLEM

Complaint / Compliments / Disputes:

If you are happy with our service, wish to make a complaint or have a dispute, you can talk to Chris Jellis - 0423 458 310

For independent support or assistance in resolving complaints: Please contact the Disability Services Commissioner; you can go directly to: 1800 677 342 (free call), TTY 1300 726 563 or www.odsc.vic.gov.au

CLIENT RESPONSIBILITIES:

This section lets you know what your expectations and responsibilities are in this agreement.

- Telling the service provider about the support that you want, and how you want to receive them.
- Being polite and respectful to the staff who work with you.
- Telling the service provider if you've got any problems.
- Telling the service provider if you can't make it to an appointment – you should always give them at least 48 hours notice.
- Telling the service provider straight away if you want to end the Agreement.

DOMAIN HEALTH (SERVICE PROVIDER) RESPONSIBILITIES:

This section lets you know what you can expect from us. We may agree on other things that are not on this list:

- Provide the services that you have asked for.
- Being open and honest about the work that they do and explain things clearly.
- Treating you politely and with respect
- Including you in all decisions about your supports.
- Letting you know what to do if you have a problem or want to complain.
- Listening to your feedback and fixing any problems quickly.
- Making sure your information is correct, up to date and kept confidential.
- Obeying all the rules and laws that apply.
- Providing invoices and statements for your support and checking whether GST applies.
- Checking that the Agreement is working well and if any changes are required

LIMITATIONS

Please note our therapists work varying hours. Typically, our team will only respond/be available for contact during business hours. You can confirm with your clinician to note their working days.

IMPORTANT

We are not an emergency or crisis service, our team is not available for urgent or emergency care. If you suspect you are in need of urgent care please call 000

CONSENT TO SHARE INFORMATION FORM

Domain Health on occasion needs to collect information about the client for the primary purpose of providing a quality service to the client. In order to thoroughly assess, diagnose and provide therapy and support, we need to collect some personal information from you (the client). If you do not provide this information; we may be provide the most appropriate support and outcome. This information will also be used:

To ensure the process of quality treatment provision, information about the client's assessment results and progress may be given to other relevant service providers or other professionals within the team, who are involved in the client's management.

Disclosure of information to the client's doctors and other members of the client's care team enable our Therapists to provide and facilitate the best possible care and outcomes. Consent will be requested from the client or their guardian / decision makers prior to contacting other care team members.

Domain Health has a Privacy Policy that is available on request. This policy provides guidelines on the collection, use, disclosure and security of the client's information. The Privacy Policy contains information on how you may request access to, and correction of, the client's personal information

CONSENT TO PHOTOGRAPHY AND MEDIA ATTAINMENT

Therapists at Domain Health will sometimes be required to make voice and video recordings as well as take photos of the client and their environment to be used solely for the purpose of analysis and individual therapy planning. Consent will be requested prior to the collection of the needed media.

CONSENT TO PHYSICAL GUIDANCE

Physical guidance contact between the client and their treating Therapist as necessary. I acknowledge that all care is taken whilst working with the client however physical contact may be required for guidance during therapy sessions, and that such contact will only be used to ensure the best outcome for the client.

I understand physical guidance may involve hand-over-hand prompting, guiding the client into a seated position etc.

I, _____, have read the above information and understand the reasons for collecting the information and the ways in which the information may be used. I understand that it is my choice as to what information I provide, and that withholding or falsifying information might act against the best interests of the client's assessment and therapy progress. I am aware that I can access personal and treatment information on request and if necessary. I understand that the Practice must obtain additional consent if the information collected is to be used in any ways other than that outlined above. I am aware and understand the fees and services structure and am aware of the cancellation policy.

I, _____ consent to the above Terms and Conditions in relation to _____.

Signed: _____ Date: _____