## **REFERRAL FOR ORTHOTIC AND/OR PROSTHETIC SERVICES** (ASSISTIVE TECHNOLOGY - AT)



## **PATIENT INFORMATION**

Address       Email         Contact Number       N         Contact Person (If not peterlet)       N         Interpreter Review       N         Secondary Managed       Secondary Managed         Funding Number       Secondary Managed         Funding Number       Secondary Managed         Funding Number       Plan End Outer         Secondary Managed       Plan End Outer         Plan Star David Verture       N       Y       Funding Number         Plan Star David Verture       N       Y       Funding Number         Contact Email       N       Y       Funding Number         Plan Star David Verture       N       Y       Funding Number         Plan Star David Verture       N       Y       Funding Number         Secondary Barbon Verture       N       Y       Funding Number         Plan Star David Verture       N       Y       Funding Number         Contact Number       N       Y       Funding Number         Primary Diavis / Functional Goals       N       Y       Funding Number         Response Dividities Relevant to Reterral       Second Reterral       Second Reterral         Primary Diavis / Functional Goals       Second Reterral       Second Reterral	First Name	Surname			Date of Birth		
Contact Person (if not patient)       N       Y       Language         FUNDING INFORMATION       E       Compensable / Insurance       LSA       Aged Care Package         Funding Body       NDIS       DV       Compensable / Insurance       LSA       Aged Care Package         Funding number       Contact Person and Company       E       E       Aged Care Package         Contact Enail       Contact Enail       Plan Start Date       Plan End Date       E         Plan Start Date       Plan Managed       Agency Managed       E       E         Plan Start Date       Plane Rend Date       E       E       E         Comorbidities Relevant to Referral       N       Y       Funding Allocated S       E         Primary Diagnosis / Reason for Referral       N       Y       Funding Allocated S       E         Proposed Orthotic/Prosthetic: Tratment       E       E       E       E       E         Primary Diagnosis / Reason for Referral       E       E       E       E       E         Proposed Orthotic/Prosthetic: Tratment       E       E       E       E       E         Reference       E       E       E       E       E       E         Reference       E	Address						
Interpreter Required?       N       Y       Language         FUNDING INFORMATION       DVA       Compensable // surance       LSA       Aged Care Package         Funding number        Contact Person       Aged Care Package       Panding number         Contact Person and Company         Vision 2000       Aged Care Package         Contact Person and Company         Vision 2000       Aged Care Package         Plan Start Date         Plan End Date          Is Requested AT Listed On Current Plan       N       Y       Funding Allocated \$         CliniCAL INFORMATION       Plazese include any supporting documentation          Primary Diagnosis / Reason for Referral           Proposed Orthotic/Prosthetic Treatment            Therapy and/or Functional Goals            REFERENCE             Name              Name              Profession & Provider Number	Contact Number		Email				
FUNDING INFORMATION   Funding Body NDIS DVA Compensable/Insurance LSA Aged Care Package   Funding number   Contact Person Company   Contact Person Company   Contact Email   Plan Start Date   Plan Start Date Plan End Date CLINICAL INFORMATION Please Include any supporting Allocated \$ CLINICAL INFORMATION Pleases for Referral Proposed Orthotic/Prosthetic Treatment Freeprence CLINICIAL INFORMATION and the support of t	Contact Person (if not patient)						
Funding Body NDIS DVA Compensable/Issue LSA Aged Care Package     Funding number     Contact Person Organization     Contact Person Organization     Contact Person Organization     Plan Type Self-Managed     Plan Statt Date Plan End Date     Statt Date V     Plan End Date     Sequested AT Listed On Current Plan     N Y   Furgersy Data Reson for Referral     Comorbidities Relevant to Referral     Proposed Orthotic/Prosthetic Trateret     Reference Linute Current Plan     N     Y     Funding Allocated     Sequested AT Listed On Current Plan     N   Y   Funding Allocated     Sequested AT Listed On Current Plan     N     Y     Sequested	Interpreter Required? N Y Language						
Funding number         Contact Person and Company         Contact Email         NISONLY         Plan Type       Self-Managed       Plan Managed       Agency Managed         Plan Type       Self-Managed       Plan Managed       Plan End Date         Plan Start Date       Plan End Date       S         CLINICAL INFORMATION       Please include any supporting documentation         Primary Diagnosis / Reason for Referral       N       Y       Funding Allocated S         Comorbidities Relevant to Referral       S       S         Proposed Orthotic/Prosthetic Treatment       S       S         REFERENC CLINICIAN INFORMATION       S       S         REFERENC SUNCIONAL INFORMATION       S       S         Referral       S       S         Name       Date of Referral       Date of Referral         Profession & Provider Number       S       S	FUNDING INFORMATION						
Contact Person and Company         Contact Email         NDIS ONLY         Plan Type       Self-Managed       Plan Managed         Plan Type       Self-Managed       Plan Managed         Plan Type       Self-Managed       Plan End Date         Plan Start Date       Plan End Date       Plan End Date         CLINICAL INFORMATION       Please include any support       S         Comorbidities Relevant to Referral       V       Funding Allocated S         Proposed Orthotic/Prosthetic Treatment       V       V         REFERENC CLINICIAN INFORMATION       Please Include S       V         REFERENC CLINICIAN INFORMATION       V       V         Name       V       V       V         Profession & Provider Number       V       V	Funding Body     NDIS     DVA     Compensable/Insurance     LSA     Aged Care Package						
Contact Email       NIX       N       Agency Managed         Plan Type       Self-Managed       Plan maged       Agency Managed         Plan Type       Self-Managed       Plan maged       Agency Managed         Plan Start Date       V       Plan End Date         Is Requested AT Listed On Current Plan       N       Y       Funding Allocated S         CLINICAL INFORMATION       Please include any support       S       S         Primary Diagnosis / Reason for Referral       V       S       S         Comorbidities Relevant to Referral       V       V       S         Proposed Orthotic/Prosthetic Treatment       V       V       S         REFERENC CLINICIAN INFORMATION       V       V       S         REFERENC Science Number       V       V       S         Name       V       V       Date of Referral         Profession & Provider Number       V       V       S	Funding number						
NDIS ONLY       Plan Type       Self-Managed       Plan Maraged       Agency Managed         Plan Start Date       Plan End Date       Plan End Date         Is Requested AT Listed On Current Plan       N       Y       Funding Allocated \$         CLINICAL INFORMATION Please include any supportion to the supportion of the support	Contact Person and Company						
Plan Type Self-Managed Plan Managed Agenue Managed   Plan Start Date Plan End Date   Is Requested AT Listed On Current Plan N Y   Funding Allocated \$   CINICAL INFORMATION Please include any support failed any suppo	Contact Email						
Plan Start Date       Plan End Date         Is Requested AT Listed On Current Plan       N       Y       Funding Allocated \$         CLINICAL INFORMATION Please Include any supporting documentation         Primary Diagnosis / Reason for Referral           Comorbidities Relevant to Referral            Proposed Orthotic/Prosthetic Treatment            Therapy and/or Functional Goals            REFERRING CLINICIAN INFORMATION            Name          Date of Referral         Profession & Provider Number							
Is Requested AT Listed On Current Plan N Y Funding Allocated \$ CLINICAL INFORMATION Please include any supporting documentation Primary Diagnosis / Reason for Referral Comorbidities Relevant to Referral Proposed Orthotic/Prosthetic Treatment Therapy and/or Functional Goals REFERRING CLINICIAN INFORMATION Name Date of Referral Profession & Provider Number	Plan Type Self-Managed Plan M	Managed Age	ency Managed				
CLINICAL INFORMATION       Please include any supporting documentation         Primary Diagnosis / Reason for Referral       Image: Comorbidities Relevant to Referral         Comorbidities Relevant to Referral       Image: Comorbidities Relevant to Referral         Proposed Orthotic/Prosthetic Treatment       Image: Comorbidities Comorbidities Relevant to Referral         Therapy and/or Functional Goals       Image: Comorbidities Referral         REFERRING CLINICIAN INFORMATION       Image: Comorbidities Referral         Name       Date of Referral         Profession & Provider Number       Image: Comorbidities Referral	Plan Start Date Plan End Date						
Primary Diagnosis / Reason for Referral         Comorbidities Relevant to Referral         Proposed Orthotic/Prosthetic Treatment         Therapy and/or Functional Goals         REFERRING CLINICIAN INFORMATION         Name       Date of Referral         Profession & Provider Number	Is Requested AT Listed On Current Plan N Y Funding Allocated \$						
Comorbidities Relevant to Referral Comorbidities Relevant to Referral Proposed Orthotic/Prosthetic Treatment Therapy and/or Functional Goals REFERRING CLINICIAN INFORMATION Referral Name Date of Referral Date of Referral	CLINICAL INFORMATION Please include any supporting documentation						
Proposed Orthotic/Prosthetic Treatment         Therapy and/or Functional Goals         FEFERRING CLINICIAN INFORMATION         REFERRING CLINICIAN INFORMATION         Name       Date of Referral         Profession & Provider Number       Date of Referral	Primary Diagnosis / Reason for Referral						
Therapy and/or Functional Goals         REFERRING CLINICIAN INFORMATION         Name       Date of Referral         Profession & Provider Number	Comorbidities Relevant to Referral						
REFERRING CLINICIAN INFORMATION         Name       Date of Referral         Profession & Provider Number	Proposed Orthotic/Prosthetic Treatment						
Name     Date of Referral       Profession & Provider Number	Therapy and/or Functional Goals						
Profession & Provider Number	REFERRING CLINICIAN INFORMATION						
	Name				Date of Referral		
Contact Number Email	Profession & Provider Number						
	Contact Number		Email				

## **Business Contact Details:** Prostek

2 William St, Mile End South SA 5031 P 08 8352 6511 W prostek.com.au E: reception@prostek.com.au