REFERRAL FOR ORTHOTIC AND/OR PROSTHETIC SERVICES (ASSISTIVE TECHNOLOGY – AT)

an oapl. clinic

PATIENT INFORMATION

First Name	Surname	Date of Birth

Address

Contact Number	Email

Contact Person (if not patient)

Interpreter Required?	N	Y	Language

FUNDING INFORMATION

Funding Body	NDIS	DVA	Compensable/Insurance	LSA	Aged Care Package

Funding number

Contact Person and Company

Contact Email

NDIS ONLY

Plan Type	Self-Managed	Plan Managed	Agency Managed

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

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

To submit this referral please save and email to reception@prostek.com.au