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

PROSTEK
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

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