



# CAIRNS OCCUPATIONAL THERAPY

## REFERRAL FORM – Residential Aged Care Facilities (RACF)

Email referral to [referrals@cairnsot.com](mailto:referrals@cairnsot.com)

Client name: _____ Preferred name: _____
DOB: _____ Address/facility where client resides: _____
Client / Carer / Primary contact person: <i>(To be contacted for appointment booking etc.)</i>
Name: _____ PH: _____
Email: _____
Invoices to be paid by: _____
Email invoices to: _____
Contact name: _____ PH: _____
<ul style="list-style-type: none"><li>• <b>Provide recent Doppler scan reports and ABPI if possible.</b> <i>If there is a concern regarding arterial blood flow, having a CT angiogram or Doppler and ABPI can be essential to ensuring appropriate and safe compression prescription for lower limbs.</i></li><li>• <i>It is important for us to have <b>updated medical information</b> for conditions that may impact on treatment (e.g. diabetes, congestive cardiac failure, peripheral neuropathy, kidney disease).</i></li></ul>
What do you feel is needed? _____ _____
Diagnosis / Medical History and Background Information: _____ _____ _____ _____
<b>Referred by:</b>
Name: _____ Email: _____
PH: _____ Signature: _____ Date: _____

P: 07 4042 6333

F: 07 4042 6390

[referrals@cairnsot.com](mailto:referrals@cairnsot.com)

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