Futures Wellness

OT New Patient Form

General Information

Title: _____ Surname: _____ First Name: _____

Address: _____ Postcode:_____

Phone (H): _____ (W): _____ (M): _____

E-mail address: _____

Date of Birth: _____ / _____ / _____ Occupation: _____

Emergency Contact: _____ Phone:_____

Relationship: _____

Medicare Card No: _____ Ref No: _____ Exp:_____

Referred by (please circle): Patient / Medical Practitioner / Google / Social Media / Website / Walk-in / Drive-by

Details:_____

Reason for referral?_____

Do you have private health insurance? Yes / No

Health Fund: _____ Health Fund No: _____

If Patient is under the age of 18, please nominate Head of Family Member:

Title: _____ Surname: _____ First Name: _____

Phone (H): _____ (W): _____ (M): _____

Date of Birth: _____ / _____ / _____ Medicare Card No: _____ IRN: ____ Exp: _____

Medical Information

Name of GP/ Pediatrician: _____ Practice Name: _____

Address: _____ Phone: _____

Are you currently seeing a medical specialist? Yes / No If yes, name: _____

Are you currently seeing any other health professionals? (Please list relevant details)

_____

Medical History

Are there any diagnosed disorders or disabilities?

☐ Yes ☐ No

Please tick the relevant boxes below:

☐ Autism Spectrum Disorder ☐ Fragile X Syndrome ☐ FASD

☐ ADHD ☐ Cerebral Palsy ☐ Acquired Brain Injury

☐ Intellectual Disability ☐ Dyslexia/Dysgraphia ☐ Developmental Delay

☐ Down's Sydrome ☐ Hearing Loss ☐ Other _____

_____

OT screener

Does your child have challenges with any of the following areas?

Self-Care:

- ☐ Dressing
- ☐ Toileting
- ☐ Shower/bath
- ☐ Grooming
- ☐ Cutlery
- ☐ Routines
- ☐ Sleep
- ☐ Transitions

Gross Motor skills:

- ☐ Strength
- ☐ Coordination
- ☐ Endurance

Play skills:

- ☐ Pretend play

Sensory:

- ☐ Understanding of one's own sensory preferences
- ☐ Advocation skills

Social skills:

- ☐ Winning/losing
- ☐ Building friendships
- ☐ Sharing/ turn taking

Fine motor skills:

- ☐ Handwriting
- ☐ Scissor skills

Domestic skills:

- ☐ Cleaning
- ☐ Washing clothes
- ☐ Meal preparation

Executive functioning skills:

- ☐ Memory
- ☐ Organisational/ planning
- ☐ Emotional regulation
- ☐ Shifting
- ☐ Self-monitoring
- ☐ Initiation

Any additional comments:

_____

_____

_____

Expectations

Research supports the importance of parent involvement in therapy sessions. Your understanding of therapy will help to foster the continued use of strategies in the home environment, thus allowing your child to make positive steps towards their OT goals.

Please comment on any expectations that you have of your Occupational Therapist:

_____

_____

_____

Behaviour & Safety

Does the client have any behavioural concerns that we should know of? ☐ Yes ☐ No

This could include biting, spitting, scratching, self harm, becoming physical or verbally abusive behaviour etc.

Notes:_____

_____

Is there a behaviour management plan in place? ☐ Yes ☐ No

For the safety of our clinicians and our clients, we require a behaviour management plan for any clients who have a history of violent or aggressive behaviour. If there is a risk of violent and aggressive behaviours but no plan is in place, please contact us before any appointments so we make suitable arrangements to manage any risks.

Is there a seizure management plan in place? ☐ Yes ☐ No

For the safety of our clinicians and our clients, we require a seizure management plan before commencing any services.

Patient Information

Please read the following information carefully before signing.

1. Policies on fees & disclosed information

1.1 I understand that appointments not attended or cancelled with less than 24 hours' notice may incur a charge and that **payment is required at the time of consultation.**

1.2 I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms provided and agree to provide any related new information during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

2. Missed Appointment Policy

2.1 Whilst we understand that there may be times when extenuating circumstances prevent you from attending your appointment or rescheduling your appointment at late notice, we must be strict, fair and consistent with all patients. By adhering to our Missed Appointment Policy, we aim not only to create a culture of mutual respect between patients, practitioners and staff, but to also improve health outcomes by ensuring a continuity of care.

2.2 Futures Wellness Clinic has a '3 strike' policy for accumulated missed appointments:

- Notification of missed appointment with opportunity to re-book at the next available time. You will be asked to refamiliarise yourself with Futures Wellness' Missed Appointment Policy.
- The full consultation fee will be charged for your missed appointment. Please be aware that you will not be able to book in any further appointments at Futures Wellness until this fee has been paid.

3. Privacy Collection Statement

3.1 We collect patient information so we can provide the best possible patient care. At times we may need to liaise with our patients' other treating health practitioners and specialists where appropriate, and with our patients' guardians or other responsible persons.

3.2 At times we may also be required to liaise with Medicare and our patients' private health insurance funds, and may need to deal with lawyers engaged by our patients, or by their private health insurance fund.

3.3 As such, we may need to disclose or allow access to patient information to others for the purposes listed above. We will never disclose patient information to overseas recipients.

3.4 If a patient does not provide us with the information we request, we may not be able to provide the patient care or products required or otherwise assist the patient.

3.5 Our Privacy Policy contains information about how individuals may access or correct personal information we hold about them, how they can complain about a breach of privacy and how we will deal with such complaints. You can find our Privacy Policy on our website at www.futureswellness.com.au or you can ask our reception staff for a copy.

4. Please Tick some or all of the following boxes as appropriate:

☐ I consent to Futures Wellness Clinic contacting me to promote their services and products

☐ I consent to Futures Wellness Clinic using and disclosing my personal information for the purposes described above.

Patient Name: _____ Date: _____

Signed: _____