**Midland Heart Housing Association**

**Occupational Therapist Referral form**

Applicants must be either chronically sick or disabled

**PLEASE NOTE THIS FORM MUST BE RETURNED WITHIN 3 MONTHS OF RECEIPT OTHERWISE THE CASE WILL BE CLOSED AND NO FURTHER ACTION TAKEN**

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| ***All sections must be fully completed otherwise the application may be delayed.***   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Failure to complete this form and return it to Midland Heart will mean that we will be unable** | | | | | | | | | | **to assist your request for work** | | |  |  |  |  |  |  | | ***I can confirm that I am happy for my medical professional to provide details of my illness/*** | | | | | | | | | | ***disability to Midland heart as failure to provide information may result in my case not being supported*** | | | | | | | | | |  |  |  |  |  |  |  |  |  |   Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_  (patient/customer) |

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| **Occupational Therapist Information** |

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| --- | --- | --- | --- |
| Occupational Therapist |  | Contact No. |  |

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| OT Team/Location |  | Email | |  | | --- | |  | |  |

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Date of Assessment

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| **Applicant Details** |

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| --- | --- | --- | --- | --- | --- |
| Title |  | First Name |  | Surname |  |

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| --- | --- | --- | --- |
| D.O.B |  | Age |  |

|  |  |
| --- | --- |
| Address |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Post Code |  | County |  | Contact Name/No |  |

Household Composition: (Including Applicant)

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Number of Adults Number of Children

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| **Property Information** |

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| Property Type |  |

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Flat: State floor and if lift served

Number of Steps at Access Reception Rooms/State whether separate

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Bathroom / State Location(s) / Floor / Bath Only / Over Bath Shower etc.

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Toilet / State Location(s) / Floor / Whether Separate to Bathroom / Outside

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Number of Dedicated bedrooms

Adaptations Already Present

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| **Functional Abilities of Applicant / Medical Condition** |

***Please provide detailed information***: l

Medical Condition / Functional abilities and potential for deterioration:

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Mobility: Ambulant / Wheelchair / Equipment Required

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Transfer Abilities: Equipment / Assistance

Continence Issues: How Managed (if applicable)

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| **Options Considered / Rejected** |

***Please provide detailed information****:* ***(Application may be delayed if all alternative equipment/adaptation provision have not been considered and reasons why not appropriate detailed below).***

*For example:*

*All applications for level access showers will not be considered unless bathing equipment and alternative solutions have been assessed and reasons why not appropriate detailed below.*

Equipment Considered and Reasons Rejected

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Alternative Adaptations Considered and Reasons Rejected

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Has Rehousing been Discussed and Reasons Rejected

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Has DFG / Alternative Funding been explored and Reasons Rejected

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| **Preferred Solution** |

***Please provide detailed information:***

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Date Application Completed