12 Shuman Ave. Suite 16 Augusta, Maine 04330 PH: 207-623-3900 FAX: 207-480-1541

Adult Referral Occupational Therapy Evaluation

Client Information

Name: ___________________________________ **DOB:** ____________________ **Age:** _____________

Are they their own guardian? **Yes** ☐ **No** ☐ Do they have a payee? **Yes** ☐ **No** ☐

Date of Referral: ________________ Address: ____

Residential Facility Name (If applies): ___________________________ House Manager: ___________________

Home Number:_____________________ Cell Phone:______________________ Fax: ____________________

Email: ____

Mental Health Diagnosis (if known):____

____

Medical Issues (Diagnosis): ____

____

Current Medications:____

____

Allergies:____

____

Does the client have SIB (self injurious behaviors)?: **Yes** ☐ **No** ☐

Brief Explanation: ____

____

Does the client have aggression/unsafe behavior towards others?: **Yes** ☐ **No** ☐

Brief Explanation: ____

____

Contact Requesting Eval Information

Contact requesting eval: _____________________________ Relationship to Client: _____________________

Agency (If applicable)**:** ____________________________ Phone Number: ____________________________

Email: ____ Fax Number: ________________________________

Address:____

How did you hear about Gallant Therapy Services? (Check all that apply)

☐ Facebook ☐ Vocational Rehab ☐ Case Manager (what agency?) ________________________

☐ Doctor Office (what office?) ______________________________ ☐ Friend ☐ Instagram

☐ Other (please share) ____________________________________

Reason for client being referred for Occupational Therapy(OT)?

(What are staff/guardian concerns, what would staff/guardians like Client to work on for skills?)

____

____

____

****Please provide us with the contact information needed to schedule the client. If we should reach out to the client directly to schedule please write their name on the line. If the Guardian or Case Manager will be setting up the date and time please put them on the line provided****

Primary Contact for Scheduling:____

Relationship to Client: ________________________ **Phone Number:**______________________________

Fax Number:________________________________ **Email:**_______________________________________

Information on Current Services

(Write agency that provides services on line provided)

☐ **Primary Care Doctor:** ________________________ ☐ **Residential Facility:** ________________________

☐ **Community Supports:** ________________________ ☐ **Vocational Rehab:** ________________________

☐ **Counseling/Psychiatrist:** ______________________ ☐ **Physical Therapy:** ________________________

☐ **Occupational Therapy:**________________________ ☐ **Speech Therapy:** ________________________

☐ **Medication Provider:** ________________________ ☐ **Education:** ______________________________

IF APPLICABLE

Guardian Information

Guardian Name:______________________________

Contact Number: ____________________________ **Email:** ___________________________________

Address: ____

Relationship to Client: ____

Case Manager Information

Name:______________________________ **Agency:** ___________________________________

Contact Number:_________________________ **Email:**________________________________

Address: ____

Agency Fax Number: ________________________________

Representative Payee Information

Name:________________________________ **Agency:**________________________________

Contact Number: ________________________ **Email:** ________________________________

Address: ____

Relationship to Client: ____

Staffing Information

Agency providing staff: ________________________________

Staff Title (type of staff ex: MHRT-1, PSS, DSP etc.): ________________________________

Frequency of Staff (Days a week/hours): ________________________________

Staff Ratio(1:1, 2:1, etc.):________________________________

Please mail or fax applicable documents prior to client's first visit

- ⏪ Person Centered Plan (PCP)
- ⏪ Psychological Evals
- ⏪ Vocational Rehab Evals
- ⏪ Medication List
- ⏪ Diagnosis (Last doctors appointment etc.)
- ⏪ Any other pertinent information

Fax to: 480-1541

Mail to: Gallant Therapy Services

12 Shuman Ave. Suite 16 Augusta, ME 04330

Email to: Hannah Pullen hpullen@gallanttherapyservices.com

Call the office at 207-623-3900