|  |
| --- |
| **Client Details (Complete for person requiring supports)** |
| Client Name |  | DOB | Click or tap to enter a date. |
| Gender | [ ]  Male [ ]  Female [ ]  Other (please specify): |
| Email |  | Phone |  |
| Address |  |
| Suburb |  | Postcode |  |
| Communicate with | [ ]  Client [ ]  Referrer [ ]  Authorised Person | If ‘Authorised Person’, please provide details below: |
| Name |  | Relationship |  |
| Email |  | Phone |  |

|  |
| --- |
| **Referrer Details (Person making this referral, if not the client)** |
| Referrer |  | Role |  |
| Email |  | Phone |  |
| Company |  |

|  |
| --- |
| **Service Details** |
| What services are required (select multiple if necessary) | [ ]  Occupational Therapy[ ]  OT Driving Assessment[ ]  Speech Pathology | *Please provide details of service/s required (assessment, report, capacity building, communication, swallowing therapy etc.)* |
| Diagnosis / Diagnoses(list all that are applicable) |  |
| Preferred Location for Service Delivery | [ ]  Home [ ]  School [ ]  Community [ ]  Clinic [ ]  Telehealth |
| Are there any safety concerns our team should be aware of? (e.g.: mental health, violence, criminality, smoking / substance use, behaviours of concern)?  | [ ]  No [ ]  Yes (If ‘yes’, please state below): |

|  |
| --- |
| **Payment for Services** |
| Payment method | [ ]  NDIS Funded (complete below) [ ]  Privately Funded [ ]  Other: |
| NDIS Number |  | NDIS Plan Dates | Start:  | End: |
| NDIS Fund Management | [ ]  Agency / NDIA Managed [ ]  Self-Managed [ ]  Plan Managed (complete below) |
| Plan Manager |  |
| Email for Invoices |  |

Other Details: