|  |  |  |  |
| --- | --- | --- | --- |
| **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: