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NDIS Client Intake Form

Section A: Client Referral Details

Full Name: **Gender:** **D.O.B:**

Address: **Region:**

Contact Number: **Email Address:**

NDIS Reference Number: **NDIS Plan Dates:**

Preferred Language: **Interpreter Required:** Yes ___ No ___

Living Arrangement: Alone ☐ Family/Partner ☐ Supported Accommodation ☐ Other ☐ _____

Does the client identify as an Aboriginal or Torres Strait Islander? Yes ☐ No ☐
**If yes, please specify:*

Does the client identify as Culturally and Linguistically Diverse (CALD)? Yes ☐ No ☐

Is the client referring themselves? Yes ☐ (if self-referral, note *'As above,'* in Section B) No ☐

Section B: Referring Details/Alternate Contact/Guardianship

Name of Organisation (if applicable):

Job Title/Role: Family Member ☐ Support Coordinator ☐ Case Manager ☐ LAC ☐

Referrer Name: **Referrer Contact Number:**

Referrer Email Address:

Alternate Contact/Nominee Name (if applicable):

Relationship to Client: **Alternate Contact Number:**

Guardian Name (if applicable):

Is there an active Guardian? Yes ☐ No ☐ **Guardianship Provisions:** Health ☐ Accommodation ☐ Other ☐ _____

Guardian Name: **Guardian Contact Number:**

Guardian Email Address:

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Section C: Primary Disability *Required

Is the client's condition considered to be stable? Yes ☐ No ☐

**Please provide some information on the client's primary disability, including date of diagnosis or release from hospital. This will allow us to find the most suitable practitioner.*

Section D: Reason for Referral *Required

**Please provide some information on the client's reason for referral. This will allow us to find the most suitable practitioner.*

Section E: Services Seeking

Occupational Therapy	Ongoing Therapy ☐ Assessment ☐ *
Exercise Physiology	Ongoing Therapy ☐ Assessment ☐ *
Speech Pathology	Ongoing Therapy ☐ Assessment ☐ *
Psychology	Ongoing Therapy ☐ Assessment ☐ *
***If requiring an assessment:**	
Occupational Therapy:	Functional Capacity ☐ Comprehensive ☐ Supported Independent Living ☐ Assistive Technology ☐ Home Modifications ☐ **Other** ☐ _____
Exercise Physiology:	Comprehensive ☐ Functional Capacity ☐ **Other** ☐ _____

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Speech Pathology:	Assistive Technology ☐ Functional Communication ☐ Comprehensive ☐ Feeding/Swallow/Mealtime ☐ **Other** ☐ _____
Psychology:	Psychosocial ☐ Cognitive ☐ Behavioural ☐ Comprehensive ☐ **Other** ☐ _____

Service Location Preference: Home ☐ Clinic ☐ School ☐ _____ **Other** ☐ _____

Section F: Eligibility Screen

Is this client open to engaging with Telehealth (online) services? Yes ☐ No ☐

Does this client have access to Telehealth (online) facilities? Yes ☐ No ☐ Requires Assistance (if yes) ☐

Does this client have communication difficulties? Yes ☐ * No ☐

Is this client verbal? Yes ☐ No ☐

**If this client has communication difficulties, please provide further detail here:*

Does this client make their own decisions? Yes ☐ No ☐

** *If no, who supports this client in their decision making?*

Are there any legal arrangements in place for this client (e.g. court orders/custody)? Yes ☐ * No ☐

☐ **If yes, please specify details here:*

Section G: Risk Screen

Is there a recent history of acute mental illness or acute psychosocial distress (mood disorders, acute psychoses, etc.) including hospital admission? Yes ☐ * No ☐

**If answered yes, please provide further detail here:*

Is there a history of suicidal ideation within the last 14 days? Yes ☐ No ☐

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Does the client feel emotional distress on a daily basis? Yes ☐ No ☐*

Is the client's NDIS Plan funded by Early Childhood Early Intervention (ECEI)? Yes ☐ No ☐*

Does this client have a Positive Behaviour Support ☐

**If yes, please specify the Positive Behaviour Practitioner who was the author here:*

Does this client have any plans of service delivery within external organisations (Hospitals/ Inpatient Wards/ Ambulance/ Police/ Helplines/ etc)? Yes ☐ No ☐*

**If yes, please specify whom with here:*

If applicable, does this client have an Educational Plan (EP)/ Individual Curriculum Plan (ICP)/ Highly Individualised Curriculum (HIC) in place? Yes ☐ No ☐*

Does the client experience swallowing difficulties related to their disability during drinking and mealtimes? Yes ☐ No ☐*

**If answered yes, please provide further detail here:*

Does this client experience difficulties with pressure care management? Yes ☐ No ☐

**If answered yes, please provide further detail here:*

Does the client have a history of falls (within the last 6 months)? Yes ☐ No ☐

Is the client able to complete daily living tasks appropriate for their age? Yes ☐ No ☐

**If answered no, please provide further detail here:*

Section H: Advocacy Information

Would you like to have an Advocate present at your appointment? Yes ☐ No ☐*

If answered **'no' please skip to Section G*

Name of Advocate:	**Contact Number of Advocate:**

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Section I: Payment of Account Details

How is this account managed? NDIA ☐ Plan-Managed ☐ Self-Managed ☐

What organisation manages this account (if applicable)?

Support Coordinator Name (if applicable):

Organisation Contact Details (if applicable):

Are there any external agencies (OPG/CSO/etc.) involved with this client? Yes ☐* No ☐

**If there are external agencies involved, please specify here:*

If there is any further information you would like to supply, please feel free to do so in this space: