



Lifestyle Therapies & Training Solutions

...passionate about Allied Health in Queensland!

Lifestyle Therapies and Training Solutions: 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 <input type="checkbox"/> No <input type="checkbox"/>	
Living Arrangement: Alone <input type="checkbox"/> Family/Partner <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Other <input type="checkbox"/> _____		
Does the client identify as an Aboriginal or Torres Strait Islander? Yes <input type="checkbox"/> * No <input type="checkbox"/> <i>*If yes, please specify:</i>		
Is the client referring themselves? Yes <input type="checkbox"/> (if self-referral, note 'As above,' in Section B) No <input type="checkbox"/>		

Section B: Referring Details	
Name of Organisation (if applicable):	
Job Title/Role: Family Member <input type="checkbox"/> Support Coordinator <input type="checkbox"/> Case Manager <input type="checkbox"/> LAC <input type="checkbox"/>	
Referrer Name:	Referrer Contact Number:
Referrer Email Address:	
Alternate Contact/Nominee (if applicable)	
Relationship to Client:	Alternate Contact Number:
Guardian Details (if applicable)	
Is there an active Guardian? Yes <input type="checkbox"/> No <input type="checkbox"/>	Guardianship Provisions: Health <input type="checkbox"/> Accommodation <input type="checkbox"/> Other <input type="checkbox"/> _____
Guardian Name:	Guardian Contact Number:
Guardian Email Address:	



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Section C: Primary Disability/Reason for Referral *Required

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

Section D: Services Seeking

Occupational Therapy	Ongoing Therapy <input type="checkbox"/> Assessment <input type="checkbox"/> *
Speech Pathology	Ongoing Therapy <input type="checkbox"/> Assessment <input type="checkbox"/> *
Exercise Physiology	Ongoing Therapy <input type="checkbox"/> Assessment <input type="checkbox"/> *
Psychology	Ongoing Therapy <input type="checkbox"/> Assessment <input type="checkbox"/> *
*If requiring an assessment:	
Occupational Therapy:	Functional Capacity <input type="checkbox"/> Comprehensive <input type="checkbox"/> Supported Independent Living <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Home Modifications <input type="checkbox"/> Other <input type="checkbox"/> _____
Speech Pathology:	Assistive Technology <input type="checkbox"/> Functional Communication <input type="checkbox"/> Comprehensive <input type="checkbox"/> <input type="checkbox"/> Feeding/Swallow/Mealtime <input type="checkbox"/> Other <input type="checkbox"/> _____
Exercise Physiology	Comprehensive <input type="checkbox"/> Functional <input type="checkbox"/> Other <input type="checkbox"/> _____
Psychology:	Psychosocial <input type="checkbox"/> Cognitive <input type="checkbox"/> Behavioural <input type="checkbox"/> Comprehensive <input type="checkbox"/> Other <input type="checkbox"/> _____
Service Location Preference: Home <input type="checkbox"/> Clinic <input type="checkbox"/> School <input type="checkbox"/> _____ Other <input type="checkbox"/> _____	



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Section E: Eligibility & Risk 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:*

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

Section F: 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 G: 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: