Lifestyle Therapies
& Training Solutions
...passionate about Allied Health in Queensland!

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:		

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** ☐ _____

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 ☐

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 Plan (PBSP) in place? Yes ☐ No ☐*
**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:**

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: