



Lifestyle Therapies & Training Solutions

...passionate about Allied Health in Queensland!

General/Private Client Intake Form

Section A: Client Referral Details	
Full Name:	D.O.B:
Address:	Region:
Contact Number:	Email Address:
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>	
Does the client identify as Culturally and Linguistically Diverse (CALD)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the client referring themselves? Yes <input type="checkbox"/> No <input type="checkbox"/> (note, 'as above,' is this is a self-referral)	
Section B: Referring Details	
Name of Organisation (if applicable):	
Job Title/Role: Family Member <input type="checkbox"/> Case Manager <input type="checkbox"/> Other <input type="checkbox"/> * _____	
Referrer Name:	Referrer Contact Number:
Referrer Email Address:	
Alternate Contact/Nominee Name:	Contact Number:
Guardian Details (if applicable)	
Guardian Name:	Contact Number:
Guardian Email Address:	
Section C: Primary Disability *Required	
Is the client's condition considered as stable? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If this client has a confirmed diagnosis, 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.</i>	



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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

Discipline Type: Occupational Therapy Speech Pathology Psychology

Please tick which type of service you are seeking:

<input type="checkbox"/> Private Therapy:	Regular, ongoing therapy funded privately.
<input type="checkbox"/> Summary Assessment:	A shorter assessment that includes an Assessment Appointment (60 minutes) and a report of findings and recommendations. <i>*Total of up to 3 hours charged.</i>
<input type="checkbox"/> Comprehensive Assessment:	A longer, more detailed assessment that includes an Assessment Appointment (60-120 minutes), and an extensive report of findings and recommendations. <i>*Total of up to 8 hours charged.</i>

Important Information: Costs for these sessions are subject to location and duration of services. For individualised quotes, please contact our administration team.

Extra Comments/Additional Information:



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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

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 psychological distress (mood disorders, 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

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 *



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Does this client have difficulties swallowing? 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:*

Is there a history of pain associated with the client's disability within the last 14 days? Yes No *

**If yes, please specify details 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: Payment Details

Name of Payer:

Email address invoices will be sent to:

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

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

Additional Comments: