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 ☐ 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 ☐ No ☐ *(note, 'as above,' is this is a self-referral)*	
Section B: Referring Details	
Name of Organisation (if applicable):	
Job Title/Role: Family Member ☐ Case Manager ☐ Other ☐* _____	
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 ☐ No ☐	
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.	

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:

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

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:

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 ☐*

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: