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| **CLIENT DETAILS** | | | | | | | | |
| **First Name (s)** |  | | **Surname** | | |  | | |
| **D.O.B** |  | | **Gender** | | |  | | |
| **Address** |  | | | | | | | |
| **Suburb** |  | | **Postcode** | | |  | | |
| **Postal Address**  (if different) |  | | | | | | | |
| **Suburb** |  | | **Postcode** | | |  | | |
| **Email** |  | | | | | | | |
| **Home Phone** |  | | **Mobile** | | |  | | |
| **Next of Kin** |  | | **Contact** | | |  | | |
| **Medicare no.** |  | | **Ref. No. on Card** | | |  | | |
| **DVA card no.** |  | | **Gold** | | |  | **White** |  |
| **Private Health fund** |  | | **Membership no** | | |  | | |
| **NDIS no.** |  | | **NDIS Plan Dates** | | |  | | |
| **NDIS managed by** | * **Agency** * **Self** * **Plan Managed (Please list Plan Manager’s contact details below)**   **- Plan Manager Company name:\_\_\_\_\_\_\_\_\_ \_\_\_\_**  **- Plan Manager Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**  ***Please attach a copy of your NDIS Plan or provide list of current goals*** | | | | | | | |
| **Relevant Medical/ Disability History** | | | | | | | | |
| **Current medical/ disability concerns** | |  | | | | | | |
| **Past medical/ disability concerns** | |  | | | | | | |
| **Referral Request** | | | | | | | | |
| **Services requested** | |  | | | | | | |
| **GP/Specialist details** | | | | | | | | |
| **GP Name** | |  | | **GP Clinic** | |  | | |
| **GP Phone** | |  | |
| **Specialists Name** | |  | | **Specialist Practice name** | |  | | |
| **Specialists Phone** | |  | |
| **School attending**  *(if applicable)* | |  | | **Year level**  *(if applicable)* | |  | | |
| **Referrer information** | | | | | | | | |
| **Name** | |  | | **Organisation** |  | | | |
| **Phone** | |  | | **Fax** |  | | | |
| **Provider no.** | |  | | | | | | |
| **Email** | |  | | | | | | |
| **Signature** | |  | | **Referral date** |  | | | |

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| **CLIENT QUESTIONNAIRE**  Information provided will enable us to effectively tailor your therapy intervention.  Thank you for your valuable input. | | | |
| **Additional medical information** | | | |
| Allergies (If yes, please list) | Yes | No | |
| Current Medications (Please list) | | | |
| Continence: 🞏 Continent 🞎 Incontinent bladder 🞎 Incontinent bowel  Management: | | | |
| Have you had a hearing test?  If yes, what were the results | Yes | | No |
| Have you had a vision test?  If yes, what were the results | Yes | | No |
| Have you had any past assessments or therapy intervention?  If yes, please provide details and copies of any relevant reports  1.  2.  3. | Yes | | No |
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| **About you** |
| Are there any cultural beliefs you would like to tell us about? Please advise |
| What are your interests? |
| Are you involved in any community activities? Please list |
| Please describe any concerns you have in the following areas;  Communication skills:  Social skills:  Gross motor skills:  Fine motor skills:  Behaviour: |
| **Performance in Daily Activities** |

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| **SELF CARE (Personal Activities of Daily Living)** | |
| **Showering** | 🞏 Independent 🞎 Assisted 🞎 Dependent  Equipment in place:  If difficult, what aspects of showering do you struggle with? |
| **Dressing** | 🞏 Independent 🞏 Assisted 🞎 Dependent  If difficult, what items are hard to put on/off? |
| **Toileting** | 🞏Independent 🞎 Assisted 🞎 Dependent  If difficult, what aspects of toileting do you struggle with? |
| **Grooming** (e.g. shaving, brushing your hair, putting on make up) | 🞏 Independent 🞏 Assisted 🞎 Dependent  If difficult, what tasks do you struggle with? |
| **Dental Hygiene** | 🞏Independent 🞏 Assisted 🞎 Dependent  If difficult, what tasks do you struggle with? |
| **Feeding** | 🞏Independent 🞏 Assisted 🞎 Dependent  If difficult, what aspect do you struggle with? |
| **Sleeping** | **Transfers**  Can you get in/out of the bed on your own? 🞏 Yes 🞎 No  **Sleep hygiene**  Do you fall asleep easily? 🞏 Yes 🞎 No  Do you wake up multiple time during the night? 🞏 Yes 🞎 No |

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| **HOUSE HOLD MANAGEMENT (Instrumental Activities of Daily Living)** | | |
| **Cooking/ meal prep** | 🞏 Independent 🞏 Assisted 🞎 Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Cleaning** | 🞏 Independent 🞎 Assisted 🞏Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Laundry** | 🞏 Independent 🞏 Assisted 🞏Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Shopping** | 🞎 Independent 🞏 Assisted 🞎Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Gardening** | 🞎 Independent 🞏 Assisted 🞎Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Finances** | 🞎 Independent 🞏 Assisted 🞏 Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Telephone** | 🞏Independent 🞏 Assisted 🞎 Dependent 🞏N/A  If difficult, what aspect do you struggle with? |
| **Transport** | 🞏 Independent 🞏 Assisted 🞏Dependent 🞏N/A  If difficult, what aspect do you struggle with? |