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| --- |
| **CLIENT DETAILS** |
| **Surname** |  | **First Name (s)** |  |
| **D.O.B** |  | **Gender** |  |
| **Address** |  |
| **Suburb** |  | **Postcode** |  |
| **Email** |  |
| **Home Phone** |  | **Mobile** |  |
| **Guardian** |  | **Contact** |  |
| **Medicare no.** |  | **Ref No. on Card** |  |
| **Private Health Fund** |  | **Membership #** |  |
| **NDIS participant 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Support Coordinator** *(if applicable)* | **Name** |  | **Company** |  |
| **Phone** |  | **Email** |  |
| **Relevant Medical History** |
| **Current concerns/ medical conditions** |  |
| **Past relevant medical history** |  |
| **Referral Request** |
| **Services requested** |  |
| **Allied Health Assistant (AHA) Option** | **Due to long wait times for ongoing OT services, we offer Allied Health Assistant (AHA) services. This process requires an initial assessment by a qualified Occupational Therapist, followed by the creation of an AHA program. Our therapy assistant will then carry out this program.****Would you like to be offered this option? (Please circle) Yes No** |
| **GP/Specialist details** |
| **GP Name** |  | **GP Clinic** |  |
| **GP Phone** |  |
| **Specialists Name** |  | **Specialist Practice name** |  |
| **Specialists Phone** |  |
| **School attending** *(if applicable)* |  | **Year level***(if applicable)* |  |