|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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)* | | |  | |