Client Intake Form

Form
201

Note: -

- ✓ *Indicates mandatory sections to be filled. Any missing information will delay the process.
- ✓ All scanned or soft copies to be sent to admin@ingoodhandsot.com.au

*** Participant's Details**							
Client Name				Date of Referral			
Date of Birth		Gender Identity		Pronoun		Sex	
Address							
Contact	Phone						
	Email						

*** Participant's NDIS Information**	
NDIS Participant Number	
Plan Start Date	Plan End Date
Medicare Card Number	
* NDIS Plan Details (Client managed by – Agency Managed, Plan Managed , Self-Managed ,Other methods	

*** Referrer's Details**		
Relationship	☐ Support Worker ☐ Agency ☐ Others ___________________________	
Name		
Address		
Contact	Mobile	
	Email	

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* Plan Manager's Details		
Plan Manager		
Company Name		
Address		
Contact	Phone	
	Email	

* Diagnosis and additional information	*NDIS Goals
	1. 2. 3. 4.

Note: *Please provide as detailed information as possible regarding diagnosis and current interventions. Please attach any existing reports to this referral form.*

*Emergency Contact Information		
Relationship		
Name		
Address		
Contact	Mobile	
	Email	

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OT Assessment (Tentative Hours Required)	
	☐ Activities of Daily Living (ADL) (10-15 hrs)
	☐ Functional Capacity Assessment with Simple Home Modification (15-20 hrs)
	☐ Sensory Assessment (10-15 hrs)
	☐ Hand Therapy Assessment and Intervention (10-15 hrs)
	☐ Orthotics Fabrication (5-10 hrs)
	☐ Paediatric Assessment and Intervention (10-15 hrs)
	☐ Assistive Technology Prescriptions (10-15 hrs)
	☐ Assessment for Support Needs and / or SIL Accommodation (20-25 hrs)
	☐ Assessment for Specialist Disability Accommodation (30 hrs or more)
	☐ Assessment for Complex Home Modification *(Please discuss this type of*
	Available funds / hours: OT services

*Applicable Code

☐ Capacity Building OT (15_617_0128_1_3) ☐ Daily Activities OT (11_661_0128_1_3)

☐ Therapy Assistant Level 1 (15_052_0128_1_3) ☐ Therapy Assistant Level 2 (15_053_0128_1_3)

*Payment method if not funded through NDIS

☐ Medicare ☐ Debit Card ☐ Other (Specify) ________________

☐ Credit Card ☐ EFTPOS

Consent Given by Participant / Client

I give consent for the following people to exchange information concerning my client / participant's welfare -Psychiatrist, General Practitioner (GP), Treating Referrer, School, Service Provider, NDIS Agency

I give consent for "In Good Hands Occupational Therapy Pty Ltd " to engage in services in relation to the above mentioned, I understand invoicing will occur in accordance with the NDIS price guide 2022-2023 incorporating Modified Monash Model (MMM) travel category where applicable.

Participant /Agency Name			
Signature		**Date**	

Cancellation Policy: - Any cancellation or reschedule made less than 5 working days will result in a cancellation fee. The amount of the fee will be equal to the reserved services hours.

Facilities Available :- Visual Sensory Room, Motor Sensory Room, Auditory Sensory Room, Tactile Sensory Room