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| **Client Intake Form** |
| **Client details** |
| Name |  |
| Date of Birth |  | Gender | F |[ ]  M |[ ]
| Address |  |
| Email address |  |
| Phone number |  |
| **Person to contact to make appointments**  |
| Name  |  |
| Phone |  | Email |  |
| **Person responsible for signing documents** **(if applicable)** |
| Name |  |
| Phone |  | Email |  |
| **Emergency contact** |
| Name |  |
| Phone number  |  |
| **Referrer** |
| Name |  |
| Organisation  |  |
| Phone  |  | Email |  |
| **Coordinator of supports / Case Manager (if not referrer)** |
| Name |  |
| Organisation |  |
| Phone  |  | Email |  |
| **General Practitioner details**  |
| Name  |  |
| Phone Number |  |
| Address |  |
| **Medical Specialist details**  |
| [ ]  Neurologist | Name  |  |
| [ ]  Rehabilitation Medicine Specialist | Name |  |
| [ ]  ENT | Name |  |
| **Referral details** |
| Reason for referral  |  |
| Diagnosis |  |
| **Service(s) required *(check all required)*** |
| [ ]  Rehabilitation Medicine Specialist [ ]  Physiotherapy [ ]  Speech Pathology [ ]  Exercise Physiology [ ]  Psychology [ ]  Neuromuscular Orthotist [ ]  Therapy Aide [ ]  Hydrotherapy  [ ]  Multidisciplinary Tone clinic [ ]  Dizziness Clinic |
| What are your preferred Days for appointments? (check box) |
| [ ]  Monday [ ]  Tuesday [ ]  Wednesday [ ]  Thursday [ ]  Friday |
| What is your preferred Time of Day? (check box) [ ]  AM [ ]  PM |
| Preferred Location of appointments: (please select all that apply) |
| [ ]  Neuro Alliance Clinic [ ]  Home Visits [ ]  Other – Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Funding source** |
| [ ]  iCare [ ]  Community Care Package [ ]  NDIS [ ]  Other: List Click or tap here to enter text. |
| Please advise how many hours are available for service/s requested  |  |
| Client number (NDIS, iCare, other) |  |
| NDIS plan start and finish dates  |  |
| Support Coordinator/Case Manager:(Name and contact information) |  |
| NDIS funds management | [ ]  Self-managed [ ]  Plan Managed [ ]  NDIS Managed  |
| NDIS Plan Manager details |  |
| NDIS Goals (please list goals on plan or provide copy of plan if available) |  |
| Please attach any other relevant documents | [ ]  NDIS plan [ ]  iCare myPlan [ ]  Discharge summaries [ ]  Specialist reports |
| Are there any relevant behavioural issues  | [ ]  No[ ]  Yes: Please specify Click or tap here to enter text.(attach behavioural support plan if available) |
| Are there any safety concerns or special considerations at place of residence  | [ ]  No[ ]  Yes: Please specify Click or tap here to enter text.Please note Neuro Alliance may require a home visit risk assessment to be completed.  |

Please email the completed form to our client support team: clientsupport@neuroalliance.com.au

You will receive acknowledgement of referral being received within 48hours.

Kind regards,

Neuro Alliance