|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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](mailto:clientsupport@neuroalliance.com.au)

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

Kind regards,

Neuro Alliance