IRS NDIS INTAKE FORM

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| NDIS: Self-managed plan:  NDIS managed plan:  Agency managed plan:  NDIS Reference Number: NDIS Service Plan Dates: From: / / To: / / | |
| PARTICIPANT DETAILS | |
| First Name: Surname: Date of Birth:  Female  Male |  |
| Address: Own home:  Private Rental:  Supported Accommodation:  Nursing Home:  Phone Number: Home: Mobile Number:  Cultural Background: Interpreter required: Yes:  No: | |
| Primary Contact: Participant:  Next of Kin:  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Next of Kin Details First Name : Surname:  Phone Number: Home: Mobile Number:  Email Address: Relationship to Participant: | |

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| Medical History: | | |
| Plan Goals: **NDIS: Hours approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Services requested: **Physio:**  **Occupational Therapy:**  **Speech Pathology:**  **OT Driving Assessment:** | | |
| Preferred Days of service: (between the hours of 9am and 5pm, Monday to Friday only) Monday:  Tuesday:  Wednesday:  Thursday:  Friday:  Any: | | |
| REFERRER DETAILS: Referrer: Organisation:  Phone: (Work): (Mobile): Fax:  Email:  Address:  **INVOICING DETAILS:**  **Portal Service bookings required - Yes:**  **No:**  **If no, invoicing details as follows:**  Contact: Organisation:  Phone: Fax:  Email: | | |
| SUPPORT CO-ORDINATOR DETAILS (if different to referrer details): Phone: (Work) (Mobile): Fax:  Email:  Address:  **PLANNING CO-ORDINATOR DETAILS (if different to referrer details):**  Name:  Phone: Fax:  Email Address: | | |
| Why did you choose this practice? | | |
| DETAILS OF EXISTING TEAM TO SEND FEEDBACK TO: | | |
| Name: | Service: | Contact details: ie phone, email, fax |
|  | GP |  |
|  | Paediatrician |  |
|  | Medical Specialist |  |
|  | Other |  |