Our Vision is to be the primary choice for trusted quality service in community rehabilitation and disability

NDIS INTAKE FORM

Please complete ALL fields below (referrals may be delayed if information is incomplete.)

If the information is not available, please write N/A.

Please forward a copy of current NDIS plan with this intake form.

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:

Gender identity: Female ☐ Male ☐ Non- Binary ☐ Transgender ☐ Prefer not to say ☐ Other _____

Preferred pronouns: She/ her/ hers ☐ He/ him/ his ☐ They/ them/ theirs ☐ Other _____ Prefer not to say ☐

Aboriginal and/or Torres Strait Islander origin Yes ☐ No ☐

Cultural background:

Main language spoken at home: Interpreter required: Yes ☐ No ☐

Address:

Own home: ☐ Private Rental: ☐ Supported Accommodation: ☐ Nursing Home: ☐ Other _____

Phone Number: Home: Mobile Number:

Preferred method of communication

Phone ☐: Text ☐: Email ☐:

Primary Contact: Participant: ☐ Next of Kin: ☐ Other: ☐_____

Next of Kin:

First Name : Surname:

Phone Number: Home: Mobile Number:

Email Address: Relationship to Participant:

Participant Medical History:

NDIS Plan Goals:

IRS Services requested:

☐ Physiotherapy: Hours allocated: _____

☐ Occupational Therapy: Hours allocated: _____

☐ Speech Pathology: Hours allocated: _____

☐ OT Driving Assessment (requires up to 6 hours of NDIS funding,Total Cost: 1,163.94)

Preferred Days of service (between the hours of 9am and 5pm)

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any ☐

Risk Assessment:
Please detail any potential risks for our staff:

- Animals on premises: ☐
- History of Violence ☐
- Behaviours of Concern ☐
- Weapons/firearms on premises ☐

Other:

REFERRER DETAILS:
Referrer Name: Organisation:

Phone: (Work): (Mobile): Fax:

Email:

Address:

INVOICING DETAILS:

Portal Service bookings required (NDIA Managed) **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 IRS?

DETAILS OF EXISTING TEAM TO SEND FEEDBACK TO:		
Name:	Service:	Contact details: ie phone, email, fax
	GP	
	Paediatrician	
	Medical Specialist	
	Other	

Once complete, the intake form can be returned to: referral@independent-rehab.com.au

IRS is committed to protecting individuals' right to privacy. We comply with federal and state legislation relating to confidentiality and privacy. All personnel maintain the highest standards of professional practice and codes of conduct regarding the confidentiality of personal information.

Last updated Decemeber 2019