|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Intake Form** | | | | | | |
| **Client details** | | | | | | |
| Name |  | | | | | |
| Date of Birth |  | | | Gender | |  |
| Address |  | | | | | |
| Email address |  | | | | | |
| Phone number |  | | | | | |
| Are you of Aboriginal or Torres Strait Islander origin? | ☐ No  ☐ Yes, Aboriginal  ☐ Yes, Torres Strait Islander  ☐ Yes, both Aboriginal and Torres Strait Islander | | | | | |
| Preferred Language |  | | | | Interpreter Required:  Yes  No | |
| **Support Person** | | | | | | |
| Name |  | | | | | |
| Relationship |  | | | | | |
| Phone |  | Email |  | | | |
| Address |  | | | | | |
| **Referrer** | | | | | | |
| Name |  | | | | | |
| Role |  | | | | | |
| Organisation |  | | | | | |
| Phone |  | Email |  | | | |
| Date of referral |  | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Support Coordinator / Case Manager (if not referrer)** | | | | |
| Name |  | | | |
| Organisation |  | | | |
| Phone |  | Email |  | |
| **Other relevant practitioners or services involved** | | | | |
| Name  Role  Service |  | Email  Phone |  | |
| Name  Role  Service |  | Email  Phone |  | |
| Name  Role  Service |  | Email  Phone |  | |
| **Health details** | | | | |
| Injury Type | ☐ Traumatic Brain Injury ☐ Acquired Brain Injury | | | |
| Date of Injury |  | | | |
| Circumstances |  | | | |
| Severity | Post traumatic amnesia (days) | | |  |
| Loss of consciousness (days) | | |  |
| Glascow Coma Scale | | |  |
| Functional Issues  (Such as motor-sensory, cognitive, communication and emotion/behavioural) |  | | | |
| *Please attach any relevant assessments and documentation with this form* | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referral Details** | | | | | |
| Reason for referral or assistive technology goals | |  | | | |
| **Funding** | | | | | |
| Funding source | | icare  NDIS  Privately funded  Other: | | | |
| Participant number (icare, NDIS, other) | | | |  | |
| **icare contact (if applicable)** | | | | | |
| Name |  | | | | |
| Phone |  | | Email | |  |
| Have you already received approval for services through the Assistive Technology Hub?  Yes  No (*Please attach if this has been received)* | | | | | |
| **NDIS details (if applicable)** | | | | | |
| NDIS plan start and finish dates | | | |  | |
| NDIS funds management | | | | Self-managed  Plan Managed  NDIS Managed | |
| NDIS Plan Manager details | | | |  | |