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| **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 |  |

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| **Support Coordinator / Case Manager (if not referrer)** |
| Name |  |
| Organisation |  |
| Phone  |  | Email |  |
| **Other relevant practitioners or services involved** |
| NameRoleService |  | EmailPhone |  |
| NameRoleService |  | EmailPhone |  |
| NameRoleService |  | EmailPhone |  |
| **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*  |

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| **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 |  |