Before engaging with Total Care Team services can occur, the following form must be completed:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | |
| Name ( full name ) &  Preferred name |  | | | | D.O.B | |  |
| Contact details | Home |  | | Mobile | |  | |
| Biological Sex | Male Female | | | | | | |
| Gender Identity | Male  Female  Gender Neutral  Non-Binary  Intersex  Transgender  Other (Please specify) | | | | | | |
| Pronouns | She/Her | | He/Him |  |  | They/Them | |
| Residential Address |  | | | | | | |
| Email address |  | | | | | | |
| Aboriginal or Torres Strait  Islander? | Yes Please specify: No  Both | | | | | | |
| Country of Birth: |  | | | | | | |
| Culturally or Linguistically Diverse  Interpreter required | Yes  No  Yes  No | | Language spoken at home | | |  | |
| Communication | Verbal Non-Verbal Method of communication: | | | | | | |
| Preferred option for  communication | Email Post Phone | | | | | | |
| Living situation | Own home  Renting  SDA/Supported Accommodation  With family  At risk of homelessness  Temporary housing  Other: | | | | | | |

**Medical History & Interests:**

|  |  |  |
| --- | --- | --- |
| Medical Conditions & Diagnosis | . | |
| Allergies |  | Interests & hobbies: |

**Alternative/ Emergency Contact:**

|  |  |
| --- | --- |
| Name |  |
| Relationship |  |
| Phone/Mobile Number |  |
| Address |  |
| Email Address |  |
| Does the Alternative Contact need to be informed of appointments | Yes No |
| Does the Alternative Contact need to be present at appointments | Yes No |

**NDIS Participants:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NDIS Reference Number |  | | | |
| Plan Start & End Date |  | | | |
| NDIS Plan: | Self-Managed | Plan Managed | Agency Managed | |
| Plan Management Organisation |  | | | |
| Plan Managers Email address for invoicing |  | | | |
| Plan Managers phone number |  | | | |
| Support Coordination  Level 2 or  Specialist Level 3 | Support Coordination Level 2 $100.14 ph  Specialist Support Coordination $190.54 ph | | | Hours:  Hours: |
| Social Work/Occupational Therapy / Allied Health Assistance( Therapy Assistant Level2 ) -  Please specify the number of hours for ongoing therapy | Occupational Therapy $193.99 ph | | | Hours: |
| Social Work $193.99 ph | | | Hours: |
|  | Therapy Assistance $ 86.79 ph | | | Hours: |
| Please specify assistance required |  | | | |
| Are there other therapists/ agencies  involved? (please list) | Yes  No Please list: | | | |
| Please provide a copy of  NDIS Plan including NDIS Goals | NDIS Plan Attached: NDIS Goals: ( please list) | | | |

**Home Care Packages; Short Term Restorative Care & Private Referrals:**

|  |  |  |  |
| --- | --- | --- | --- |
| Aged Care ID Number |  | | |
| Social Work/Occupational Therapy/ Allied Health Assistance - Please specify the number of hours for ongoing therapy | Occupational Therapy $193.99 ph | | Hours: |
| Social Work $193.99 ph | | Hours: |
|  | Allied Health Assistance $86.79 ph | | Hours: |
| Please specify assistance required |  |  |  |
| Home Care Package | Yes | No |  |
| Short Term Restorative Care Package | Yes | No |  |
| Private Referrals | Yes | No |  |
| Email address for Invoicing |  | | |

**Referrer Details:**

|  |  |  |
| --- | --- | --- |
| Name of Organisation |  | |
| Referrer Name |  | Job Title/Role: |
| Referrer Phone Number |  | Email: |
| Referrer Address |  | |
| Referrer Signature |  | Date : |