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 StraitIslander?  |  [ ] 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 forcommunication |  [ ]  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 CoordinationLevel 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 ofNDIS 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 : |