# DISABILITY THERAPY & ASSESSMENT INTAKE FORM

**Thank you for your referral to Think Psychology Services. To ensure I can provide the best service and most appropriate services to meet the participant's needs please complete the following form in as much detail as possible.**

Date:

| PARTICIPANT DETAILS | | |
|---|---|---|
| **Name** | **DOB & Age** | **Gender** |
| **Address** | | **Email** |
| | | **Phone** |
| **Primary Contact Person** | **Phone** | **Email** |
| **Relationship to participant** | | |

| FUNDING | | |
|---|---|---|
| **NDIS** | | |
| **NDIS Number** | **NDIS Plan Start Date** | **NDIS Plan End Date** |

| Medicare | | | |
|---|---|---|---|
| **Medicare Card Number** | **Number next to name** | **Expiry Date** | **Date of MHCP:** |

| ABOUT |
|---|
| **Primary Diagnoses/ Disability:** |
| **Description of Presentation – behaviours of concern, difficulties, strengths** |

| |
|---|
| |
| **Brief Description of Living Situation (eg. alone, family, supported accommodation) & Support Arrangements** |
| |
| **Brief Description of Informal Supports – family, friends, other** |
| |

| **Please List all Previous Diagnostic letters, Assessments & Reports** | **Date** |
|---|---|
| | |

**DECISION MAKING**

**Is the participant with the Public Trustee and Guardian?**

☐ **Yes** ☐ **No**

**If Yes, Trustee Contact Details**

**Name**

**Phone**

**Email**

| Substitute Decision Making | |
|---|---|
| ☐ Self<br>☐ Guardian<br>☐ Public Guardian<br>☐ Power of Attorney<br>Other (specify) | **If not self, Decision Makers Contact Details**<br>Name<br>Organisation<br>Phone<br>Email |

| Home Visit Risk Assessment<br>(Please complete accurately to ensure the safety entering the home of the participant) | YES | NO | Details |
|---|---|---|---|
| 1. Does the participant live in an isolated area? | ☐ | ☐ | |
| 2. Is there mobile phone coverage? | ☐ | ☐ | |
| 3. Are any pets friendly | ☐ | ☐ | |
| 4. Does anyone at the property / regular visitors have a history of being aggressive/ violent? | ☐ | ☐ | |
| 5. Does anyone at the property have a history of alcohol or illicit drug dependence? | ☐ | ☐ | |
| 6. Are there firearms in the home? | ☐ | ☐ | |
| 7. Does anyone at the property have an infectious disease? | ☐ | ☐ | |
| 8. Are there any other factors relating to the safety when entering the property? | ☐ | ☐ | |

| Contacts | | | |
|---|---|---|---|
| **Support Coordinator** | | | |
| Name | Phone | Email | Organisation (if relevant) |
| | | | |
| | | | |
| **GP** | | | |
| Name | Phone | Email | Organisation (if relevant) |
| | | | |
| | | | |
| **Accommodation Provider** | | | |
| Name | Phone | Email | Organisation (if relevant) |
| | | | |

| | | | |
|---|---|---|---|
| **Supported Accommodation House** | | | |
| **Team Leader** | **Phone** | **Email** | **Organisation (if relevant)** |
| | | | |
| | | | |
| **Other Provider** | | | |
| **Name** | **Phone** | **Email** | **Organisation (if relevant)** |
| | | | |
| | | | |
| **Other Provider** | | | |
| **Name** | **Phone** | **Email** | **Organisation (if relevant)** |
| | | | |
| | | | |

| **NDIS Payments** | | | |
|---|---|---|---|
| **If therapy, how many hours are you wanting to allocate to the psychological supports requested?** (Billed under Improved Daily Living) | | | |
| **Is a quote required?** | | | |
| **Who is responsible for payment: (please tick)** | **NDIS** | **Plan Manager** | **Self** |
| | **Details for billing (if plan-managed):** | | |
| | **Details for billing (if self-managed):** | | |

| **Any other information you think needs to be shared?** |
|---|
| |

**Please return this form ASAP via email admin@thinkpsychologyservices.com or fax on 872232055.**
**Thank you for choosing Think psychology Services**