SPECIALIST TRAINING AND COUNSELLING SERVICES

ABN: 20 964 994 873
ACN: 638 814 730
Clyde North | Room 1, 7 – 9, Selandra Bvd, Clyde North Vic 3978

Date of Referral: _____ *(DD-MM-YYYY)*

CLIENT INFORMATION

NDIS Number: _____

Full Name: _____
DOB: _____ *(DD-MM-YYYY)*
Age: _____
Gender: *(optional)* _____
Preferred Gender Pronouns: *(optional)* _____
Parent/guardian: *(if under 18 years)* _____
Address: _____
State: _____
Post Code: _____
Phone: _____
E-mail: _____

Preferred form of contact: ☐ Phone ☐ Email

PLAN MANAGER DETAILS

The client is ☐ Plan Managed ☐ Self-Managed *(Pls provide name and details of person responsible for authorising invoice payments)*

Plan Manager organisation name: _____
Plan Manager email for Invoicing: _____
Name of contact person: _____ Phone: _____

REFERRING PROFESSIONAL

Full Name:

Organisation Name:

Address:

State:

Post Code:

Phone:

E-mail:

Preferred form of contact: ☐ Phone ☐ Email

Relevant Client Concerns: *(PIs include relevant risks that we need to be aware of)*

Summary of Client Goals:

History of Mental Health: *(concerns, suicidal ideation or other relevant issues)*

HOME/ON-SITE VISITS

- If home or on-site visits are required, please provide a completed Safety check/Risk assessment.

OTHER RELEVANT INFORMATION