The Fig Trees Disability Services
7 Addison Road, Pennington SA 5013
(08) 8448 3989
contact@thefigtrees.com.au

CLIENT INTAKE FORM

Required services (please tick what applies)

☐ In home and social support	☐ Group activities and school holiday programs
☐ Physiotherapy	☐ Nursing
☐ Counselling	☐ Social work
☐ Short term accommodation and respite	☐ Psychosocial recovery coaching
☐ Support coordination (level 2)	☐ Specialist support coordination (level 3)

Client details

Participant Name (Client)		D.O.B:		Gender	
NDIS Number					
Plan start date:		Plan end date:			
Contact details	Home		Mobile		
Email address					
Language spoken at home:		Interpreter required	☐ Yes ☐ No		
Preferred option for communication (phone call, text message, email or letter)		Do you identify as Aboriginal and Torres Strait Islander? ☐ Yes ☐ No			
Residential Address:					
Postal Address (if different from above)					

Next of kin, legal guardian or plan nominee details

Name:		Primary Carer	☐Yes	☐No
		Emergency Contact	☐Yes	☐No
Relationship to client:		D.O.B:		
Residential Address:				
Postal Address (if different from above)				
Contact details:				

Support coordinator's Details

Name:	
Organisation:	
Contact details:	

Referral details:

Disability / Medical Conditions: *(Please list primary disability and other medical conditions):* *Please provide care plan if applicable (for example, for diabetes or epilepsy)*	
Client's background/stories:	
Risks to self and/or others:	
Client's goals for this referral:	
Client's expectation and/or preferences of support person/therapist:	
Is there a positive behaviour support plan in place?	☐ Yes (please provide) ☐ No
Is there a guardianship order, a power of attorney or advanced care directive in place?	☐ Yes (please provide) ☐ No

Support team details (current providers the client is using, if relevant)

Name:		Organisation:	
Role:		Frequency of Use:	
Phone:		Email:	
Name:		Organisation:	
Role:		Frequency of Use:	
Phone:		Email:	
Name:		Organisation:	
Role:		Frequency of Use:	
Phone:		Email:	

Healthcare details (if relevant):

Medicare Number		Expiry Date:	
		Reference Number:	
Private Healthcare Provider		Membership Number	
		Reference Number	
GP's name:		Clinic:	
Phone:		Address:	

Funding details:

What is the budget for this requested service?	
How is the budget managed?	☐ Self-managed ☐ Plan-managed ☐ NDIA-managed
Person/Organisation managing the fund:	
Email for invoicing:	

Client's statement:

I understand that:

- These records are owned by The Fig Trees.
- Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties.
- I can ask to see records and receive a copy.
- Records are archived for a set period according to policy and procedure.
- I understand that all information obtained will be kept confidential.
- To the best of my knowledge, the information provided in this form is true and correct.

Signature	
Name of signatory	
Relationship to the participant, if not the participant	
Date	

Note: Authority to Act, Power of Attorney and Guardianship order is required if the individual signing this form is not the participant and not recognised as the plan nominee/plan representative. In case a referral is completed on client's behalf with verbal consent, please note in signature section "verbal consent obtained".