INTAKE FORM

PROVIDER ADDRESS:
2 Aver Ave DAW PARK SA 5041
Phone 8276 3355
Email: admin@enhanceot.com.au
Web: www.enhanceot.com.au

Certified System Quality ISO 9001 SAI GLOBAL

Registered NDIS Provider

ABN:63 907 367 260

Enhance OT Occupational Therapy

STEP 1: CLIENT DETAILS

Please include all client details.

STEP 2: FUNDING

☐ **PRIVATE PAY** ☐ *Insurance*

NDIS PLAN NUMBER:

☐ **NDIS - SELF MANAGED**

☐ **NDIS - AGENCY MANAGED**

☐ **NDIS - PLAN MANAGED**

PLAN MANAGER PROVIDER:

NDIS PROVIDER GUIDELINES:
A service booking must be created before service delivery to the participant commences.
The Plan Manager or NDIA (Agency) will be provided this request form to process.

STEP 3: REPRESENTATIVES

List any representatives authorised to discuss referral for OT consult.

☐ NDIS SUPPORT COORDINATOR

SPOUSE/FAMILY/FRIEND

STEP 4: MEDICAL HISTORY

The Occupational Therapist requires medical history/condition to complete clinical assessment.

STEP 5: ATTACHMENTS

Provide information to Enhance OT for assignment of suitable clinician.

☐ HEALTH SUMMARY

☐ SPECIALIST REPORTS

☐ NDIS GOALS ☐ NDIS PLAN

☐ PLAN MANAGER INFORMATION

CLIENT CONTACT DETAILS

FORM E02 - ENHANCE OT INTAKE FORM OCT

Surname: **First:**

Title: **DOB:** **Gender:**

Address:

Suburb: **Postcode:**

Mobile: **Home Ph:**

Alternate Contact: CONTACT ALTERNATE TO ARRANGE CONSULT

Alternate Phone: ☐ ALTERNATE IS REQUIRED AT CONSULT (CLIENT CONSENTS)

Usual GP: **GP Phone:**

GP Location:

Medicare No: **Ref No:**

Aboriginal and/or Torres Strait Islander origin? Yes No: NOT RECORDED

Language/Communication support required: ☐ INFORMAL FAMILY ☐ FORMAL INTERP

Provide details:

MEDICAL HISTORY/CONDITION:

List the reason for the Occupational Therapy consult:

SERVICE AGREEMENT for INTIAL CONSULT:

I understand and consent to fee $190.00 for initial 60 minutes

SIGNED:

DATE:

CLIENT SIGNED NOMINEE

AUTHORISED REPRESENTATIVE

NAME OF PERSON SIGNING:

EOT OFFICE USE ONLY

☐ COMPLETE

☐ INCOMPLETE

☐ REPLY SENT

FM E02 - EOT INTAKE FORM