

PROVIDER ADDRESS:

2 Aver Ave DAW PARK SA 5041

Fax: 8276 3377**Email:** admin@enhanceot.com.au**Web:** www.enhanceot.com.au

©Enhance Occupational Therapy Pty Ltd 2019

Please call our office for
additional information:**8276 3355****INTAKE FORM**

FM E02 - EOT INTAKE FORM JULY 2019

STEP 1: CLIENT DETAILS

Please include all client details.

STEP 2: FUNDING☐ PRIVATE PAY ☐ Insurance☐ NDIS - SELF MANAGED☐ NDIS - AGENCY MANAGED☐ NDIS - PLAN MANAGED

PLAN MANAGER

NDIS PLAN NUMBER:

STEP 3: REPRESENTATIVESList 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**EOT OFFICE USE ONLY**☐ COMPLETE - ACCEPT SELF REFERRAL☐ INCOMPLETE - SEND LETTER

FM E02 - EOT INTAKE FORM JULY 2019

CLIENT CONTACT DETAILS

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:**REQUEST FOR OCCUPATIONAL THERAPY:**

List the reason for the Occupational Therapy consult

SERVICE AGREEMENT for INTIAL CONSULT:

I understand and consent to fee \$180.00 for initial 60 minutes consult.

NAME OF PERSON SIGNING:

SIGNED:

DATE:

☐ CLIENT SIGNED☐ AUTHORISED REPRESENTATIVE