## Part 1: Client’s information

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Date of Birth |  | Gender |  |
| Address |  | | |
| Home phone |  | Aboriginal or TSI? | Choose an item. |
| Work phone |  | Main language? | Choose an item. |
| Mobile |  | Interpreter? | Choose an item. |
| Email |  | | |
| Australian Citizen? | No  Yes | | |
| Prefer contact by | Video  Phone  SMS  Email  Post  Other | | |
| Covid Vaccination Status | Vaccination 1  Vaccination 2  Booster  Not vaccinated | | |

## Disability and medical details

|  |  |  |  |
| --- | --- | --- | --- |
| Sensory | Physical | Neurological | Mental Illness |
| Deaf  Hard of Hearing  Deafened  DeafBlind  Blind  Low vision  Sensory/Auditory Processing Disorder (SPD/APD)  Other sensory | Hereditary  Congenital  Acquired  ABI/TBI  Epilepsy  Spinal Column Inju  Cerebral Palsy  Cystic Fibrosis  Multiple Sclerosis  Spina Bifida  Prader-Will Synd  Other physical | ASD (Autism)  Intellectual Disability  Develop. Delay  Global DD  Fragile X Synd.  Down Syndrome  Other chromosomal  Other neurological | Mood disorders   (such as depression or   bipolar disorder)  Anxiety disorders  Personality   disorders  Psychotic disorders   (such as schizophrenia)  Eating disorders  Trauma-related   disorders (such as   Post-Traumatic Stress   Disorder)  Substance abuse   disorders |
| Any other health issues or disabilities not listed above?  *Please describe >* | |  | |

## Referrer’s Details

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Address |  | | |
| Work phone |  | Main language? | Choose an item. |
| Mobile |  | Interpreter? | Choose an item. |
| Email |  | | |
| Prefer contact by | Video  Phone  SMS  Email  Post  Other | | |

## Reason for Referral:

|  |
| --- |
|  |

## Current providers/history:

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| --- |
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