



Intake Form

Date of Referral:

First Name:		Surname:	
DOB:		Gender:	
Diagnosis:			
Preschool/School attending (if any):			
Current year at school/Teacher's name:			
Does your child/Do you speak a language other than English at home?		If yes, please specify language spoken at home:	
Will an interpreter help us share information?			

Parent/Carer Information:

	Parent/Carer 1	Parent/Carer 2
Name:		
Relationship to child:		
Address:		
Phone:		
Email:		

Funding Source:

NDIS ☐ Private ☐ Health Fund ☐ Other ☐

NDIS Number:	
Plan Start Date:	
Plan End Date:	
Self Managed: Yes No	
Plan Managed: Yes No	Plan Manager:
NDIA Managed: Yes No	
Plan Manager Email:	
Goals listed on NDIS plan	

In what area do you need support from us?

- ☐ Orthopaedic conditions ☐ Attention and Behaviour ☐ Sensory regulation
☐ Fine & Gross Motor Skills ☐ Coordination ☐ Exercise
☐ Physical disabilities Other: _____

Please check all days and times you are available for therapy?

Monday AM PM Tuesday AM PM Wednesday AM PM
Thursday AM PM Friday AM PM

What are your most preferred times/days for therapy?

Where do you want therapy to happen? (e.g. clinic, home, community, or combination)

Additional Information and comments

Professionals involved in my child's care: (e.g. GP, Paediatrician, Allied Health, medical specialists, support coordinators/case workers)

Name:	Profession:	Location/phone number:	How often do you see them?	Consent to contact:

When you return this intake form, please also forward any relevant reports (i.e. Previous reports, hearing assessments, other allied health reports, NDIS reports). These make a huge difference for us when we are beginning to work with your child and your family.

Please email this form back to Michael at admin@thespeechspotillawarra.com when completed.