The Thrive Spot

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	

What support do you need from us?

- ☐ AAC
- ☐ Feeding
- ☐ Interaction and Conversation
- ☐ Language
- ☐ Literacy
- ☐ Other:
- ☐ Speech Sounds
- ☐ Fluency/Stuttering

Please check all days and times you are available for speech 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? (Clinic or Home)

(School or community sessions can also be arranged after therapy has commenced)

Referral source / how did you hear about us?

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 speech pathologist's 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 admin@thethrivespot.com.au