Youcentric Care Group Client Intake Form

Please fill in all relevant fields and email this form to info@youcentriccaregroup.com

Participant/Client Details					
First Name:		Last Name:		Date of Birth:	
Phone:		Email (If applicable)		Gender:	
Address:					
Disabilities:	Primary Disability				
	Other Medical Hx				
Family/Caregiver's Name:		Family/Caregiver's Phone:		Family/Caregiver's Email:	

Referrer Details			
Name:		Phone:	
Organisation and Address (if relevant):		Email:	
Relationship to Participant			
☐ Self	☐ Family	☐ Case Manager	☐ Support Co-Ordinator	☐ Local Area Co-Ordinator
☐ Other:			
Payment/ Funding Information			
☐ NDIS Managed ☐ Plan-Managed ☐ Self-Managed ☐ Private ☐ Youcentric Access Program			
Plan Managed or Billing Details (Self-Managed) Details:			

Reason for Referral (Please Tick)					
Home Modifications (Minor)	☐	Assistive Technology	☐	Functional Assessment	☒
Home Safety Assessment	☐	Sensory Profile Assessment	☐	Ongoing Therapy Services (Paeds)	☐
Manuel Handling Plan/Training	☐	Manuel Handling Plan/Training	☐	Ongoing Therapy Services (Adults 11-18)	☐
SIL/ILO Assessment	☐	SDA	☐	Letter of Recommendation	☐

☐ Other:

Home Visit Risk Assessment			
No.	Risk Factor		
1.	Living situation: ☐ Alone ☐ Family ☐ Supported Accommodation Other:		
2.	Is the participant living in an isolated area?	☐YES	☐NO
3.	Is there mobile phone coverage?	☐YES	☐NO
4.	Are pets present? (Pets to be restrained at the time of assessment)	☐YES	☐NO
5.	Does anyone at the property have a history of being aggressive/violent?	☐YES	☐NO
6.	Does anyone at the property have a history of alcohol or illicit drug dependence?	☐YES	☐NO
7.	Are there firearms in the home?	☐YES	☐NO
8.	Does anyone at the property have an infectious disease?	☐YES	☐NO
9.	Are there any other factors relating to the safety of our therapists entering the property?	☐YES	☐NO
	If Yes to any questions above, please provide further info:		