Bullinah
New NDIS INTAKE

PATIENT INFORMATION	
SURNAME:	GIVEN NAME/S:
PREFERRED NAME:	GENDER: MALE | FEMALE | NOT SPECIFIED (please circle)
DATE OF BIRTH: ____/____/_____	
NDIS Participant Number: ___ ___ ___ ___ ___ ___ ____ ___ ___ ____ ___	
NDIS Plan Start Date: _____/____/_____	NDIS PLAN EXPIRY DATE: _____/_____/_____

YOUR NDIS PLAN

Is your plan:

☐ Self managed (you manage your plan)

☐ Plan Managed (managed by a Plan Manager) – Please provide contact details:

Name: .....

Organisation: .....

Phone/Email: .....

☐ Agency Managed (managed by the NDIS)

PLEASE ATTACH A COPY OF YOUR NDIS PLAN WITH THIS FORM.

Do you have a Support Coordinator?

☐ Yes – Please provide contact details:

Name: .....

Organisation: .....

Phone/Email: .....

TYPE OF SERVICES REQUESTED

☐ Occupational Therapy ☐ Speech Pathology

☐ Dietician ☐ Social Work

☐ Exercise Physiology ☐ Psychology

☐ Early Childhood Supports

YOUR NDIS PLAN SUPPORTS

Do you have funds allocated in your plan for Therapeutic Supports or Early Childhood Intervention?

If yes, please provide details:

HOW DID YOU FIND OUT ABOUT BULLINAH'S NDIS SERVICES?

✓ **Tick which applies**

O Brochure, poster, leaflet – Where did you see this/get it from? _____

O Facebook post/ad

O Bullinah NDIS workshop/event

O Bullinah newsletter

O Referral – Who referred you?_____

O Word of mouth (friend/family member told you)

O Other – Please provide details_____

SPECIFIC REQUIREMENTS/PREFERENCES

(interests, physical/cultural/belief-based requirements):

If modifications to existing facilities or processes may be required, please describe here:

Your personal information

Bullinah may work closely with other agencies to coordinate the best support for you. We need your consent to share your information, except when:

- we are obliged by law to disclose your information regardless of consent or otherwise
- it is unreasonable or impracticable to gain consent or consent has been refused; and
- the disclosure is reasonably necessary to prevent or lessen a serious threat to the life, health or safety of a person or group of people.

I declare that all information provided on this date is true and correct at this time, I understand that providing false information is an offence. I am aware that my information is confidential and will not be discussed outside the Service except in the above situations. I agree that there will be times when the Bullinah health professionals may need to discuss my details with Specialists or other service providers and make referrals with some of my details to these service providers.

PATIENT/GUARDIAN SIGNATURE: _____

GUARDIAN NAME (if under 16yrs or other legal guardian arrangement): _____ **DATE:**_____

OFFICE USE ONLY:

Referral Details			
Date of referral:		☐ New client	☐ Returning client
☐ Non-urgent	☐ Urgent. Reason:		
Referred by:			
Contact No:		Email:	

Discussion Checklist	Comments
☐ Right to have a support person present	
☐ Right to engage an Advocate	
☐ Entry and Exit procedures	
☐ Eligibility and priority of access (Plan/funds available)	
☐ Conditions that may apply to service (eg. client not known, and requesting home visit, 2 staff to attend)	
☐ Fees	
☐ Copy of NDIS Plan	

Outcome of Intake Interview	
☐ Assessment Interview recommended	
☐ Add to waiting list	Reason:
☐ Service refused	Reason:
☐ Alternative support identified	Details:

Intake completed by:			
Name			
Signed		Date:	

ALLIED HEALTH PRACTITIONER TO COMPLETE: INITIAL APPOINTMENT BOOKING

Assessment Interview Planning			
Date:		Time:	
☐ Bullinah office			
☐ Client's home:	Address:		
☐ Other venue:	Address:		
Specific instructions re: venue			
Attendees:	☐ Supporters – Family, friends, carers		
	☐ Other Service Providers		
	☐ Advocate		
	☐ Interpreter		
Participant's communication preferences			
NDIS Plan	☐ Copy of NDIS Plan already uploaded to MD ☐ Reminder to participant to bring copy of NDIS Plan		

Initial Appointment booked by:			
Name			
Signed		Date:	