



CLIENT INTAKE FORM

River & Light Allied Health | Occupational Therapy
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Please complete this form before the first appointment. A parent, guardian or nominee may complete it where appropriate.

1. CLIENT / PARTICIPANT DETAILS

Full name

Preferred name

Date of birth

Pronouns

Gender (optional)

Residential address

Phone

Email

Preferred contact method

Preferred language

☐ Interpreter required

☐ Communication support / AAC used

2. PARENT / GUARDIAN / NOMINEE (IF APPLICABLE)

Name

Relationship to client

Phone

Email

☐ May discuss care / appointments with River & Light Allied Health

3. NDIS / FUNDING DETAILS

☐ NDIS

☐ Private

☐ Other funding

NDIS participant number

Current plan dates

☐ Self-managed

☐ Plan-managed

☐ NDIA-managed



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Plan manager / organisation

Plan manager email

Support Coordinator / Recovery Coach

Phone

Support Coordinator / Recovery Coach email

Current NDIS goals / goals you would like OT to support

4. REFERRAL INFORMATION

Referrer name

Organisation / role

Phone

Email

Reason for referral / what would you like help with?

5. HEALTH, DEVELOPMENTAL & DISABILITY INFORMATION

Primary diagnosis / disability (if known)

Other diagnoses, health conditions or relevant developmental history

Current medications relevant to therapy / safety



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Allergies / adverse reactions

Medical precautions, seizures, swallowing concerns, falls risk, behavioural or other safety concerns

Recent hospital admissions, surgery or major changes in health/function

6. CURRENT SUPPORTS & SERVICES

Current allied health / medical / support services

Family / informal supports and who the client lives with

School, daycare, study, employment or day program (if applicable)

7. FUNCTIONAL INFORMATION

Tick any areas where the client experiences difficulty or would like support:

- | | | | |
|---|---|---|---|
| ☐ Self-care | ☐ Mobility / transfers | ☐ Communication | ☐ Learning |
| ☐ Social interaction | ☐ Self-management | ☐ Sensory processing | ☐ Emotional regulation |
| ☐ Domestic tasks | ☐ Community access | ☐ School / work | ☐ Sleep / routines |

Main day-to-day difficulties, assistance required and what is currently working well

8. EQUIPMENT, HOME & ACCESS



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Current assistive technology / equipment / mobility aids

Home access or environmental concerns (stairs, bathroom, transfers, safety, accessibility)

Equipment or home modification needs you would like assessed

9. COMMUNICATION, SENSORY & PARTICIPATION PREFERENCES

How does the client best communicate and understand information? AAC, visual supports or processing needs?

Sensory preferences, triggers, regulation strategies, routines or environments that help

Strengths, interests, motivators and activities that are important to the client

10. EMERGENCY CONTACT

Emergency contact name

Relationship

Phone

Alternative phone

11. CONSENT & INFORMATION SHARING

☐ I consent to occupational therapy assessment and/or intervention.

☐ I consent to collection and storage of information required to provide services and maintain clinical records.



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☐ Where relevant, I consent to information being used to prepare NDIS reports and supporting documentation.

☐ I consent to liaison with relevant providers/supports that I have authorised.

☐ I consent to contact regarding appointments, services and clinical matters.

People / organisations River & Light Allied Health may contact or share relevant information with (or write 'none')

Any limits on consent / information sharing

12. DECLARATION & SIGNATURE

I confirm that the information provided is accurate to the best of my knowledge. I understand I can ask questions about the service, change or withdraw consent for future information sharing, and notify River & Light Allied Health if my details or circumstances change.

Name of person completing form

Relationship to client

Signature (type name electronically or sign after printing)

Date

Office use: Intake reviewed by _____ Date _____ Follow-up required: Yes / No