

NorthCoast Rehab Services

p: 07 5446 8289 f: 07 5446 7666 ACN 139 435 671

e: reception@northcoastrehab.com.au e: PO Box 397, Yandina QLD 4561



NEW NDIS CLIENT FORM

CLIENT DETAILS	
Full Name	
Date of Birth	
Address	
Home Phone Number	
Mobile Number	
Email	
Gender	Male / Female
Name of Next of Kin	
Next of Kin Phone Number	
NDIS Number	
Plan Management	<input type="checkbox"/> Plan Managed <input type="checkbox"/> NDIA Managed <input type="checkbox"/> Self-managed Details of where to send invoices:
Support Coordinator Name & contact number:	
Please Identify the Type of Disability?	
Brief Medical History (if any):	
GP's Name	
GP's Phone Number	
Mobility Status	<input type="checkbox"/> Independent <input type="checkbox"/> Assist by One <input type="checkbox"/> Assist by two <input type="checkbox"/> Using Frame <input type="checkbox"/> Using Wheel Chair <input type="checkbox"/> Bed Bound

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Sensory Impairment (if any):	<input type="checkbox"/> Visual Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Autism spectrum disorder (ASD) <input type="checkbox"/> Other: Please specify
Living Condition	<input type="checkbox"/> Living alone <input type="checkbox"/> Living with partner <input type="checkbox"/> Living with a family member <input type="checkbox"/> Living in a group home
Working Status	<input type="checkbox"/> On Disability Pension <input type="checkbox"/> Does not work <input type="checkbox"/> Working <input type="checkbox"/> Do Volunteer Work

DETAILS OF PERSON / ORGANISATION MAKING REFERRAL	
Date of Referral	----/----/----
Reason for Referral	
Desired Outcome	
First Name	
Surname	
Name of Organisation	
Contact Number	
Email	
Your Relationship to Client	
Date	