THERAPY INITIAL REFERRAL/ INTAKE FORM

Date of Referral: ____ / ____ / ____ **Parent (child clients)/ Carer:** _____

Client Name: _____

Date of Birth: ___ / ___ / ___ **Age:** _____ years _____ months

Mailing Address: _____

_____ Post code _____

Telephone: **OK to leave message?**

(Home) _____ Yes / No

(Mobile) _____ Yes / No

(Email) _____

NDIS reference number (if applicable)_____

NDIS Plan Manager (if applicable) _____

Referral Source: _____

_____

Information Provided By: _____

Referred for (circle): Individual Therapy / Assessment/ Other : _____

Presenting Problems/Issues: _____

_____

_____

_____

_____

_____

Days/times would prefer:_____

Any Current Legal Matters: _____

Any current Suicidal or Homicidal Thoughts or Intent: _____

_____

Inform of Motion Psychology Services fee: ***Agreed? Y /N***
Therapy - $150p/hr

Inform of NDIS fees: ***Agreed? Y /N***
Therapy - $195p/hr
Please note cancellation Fees apply with less than 48hrs (business day) notice.

Information Taken By: _____
Signature: _____

<u>For Office Use Only</u>: _____ Waiting List
Client Accepted For Services?: YES / NO Case File No.: 2022/_____
Assigned To: _____ Date: _____ / _____ / _____
Assigned To: _____ Date: _____ / _____ / _____