Ripples
Allied Health Consultancy

Shop 4B, 44-52 Princes Hwy, Dapto NSW 2530
Mail: PO Box 227 Dapto 2530

loanpham.ripples@gmail.com
www.ripplesahc.com.au

M: 0479 055 023
ABN: 55 816 911 851

ADULT REFERRAL FORM & INTAKE

Patient/client details

Name: _____ D.O.B.: _____

Address: _____ Phone: _____

Medicare #: _____ Mobile: _____

Medicare Ref #: _____ Expiry: _____ Email: _____

Concession #: _____ Expiry: _____ Employer: _____

NDIS#: _____ VC Approval# _____

Date of NDIS Plan: _____ Workcover #: _____ DOI: _____

Country of Birth: _____ Role/Hours #: _____

Physical Disability: _____ Nationality: _____

NDIS Ref #: _____ Plan Manager email: _____

Aboriginal or Torres Strait Islander ☐ Aboriginal ☐ T.S.I ☐ Both ☐ Neither ☐ Unknown

Significant Others (for emergencies)

Partner's Name: _____ Phone: _____

Address: _____ Mobile: _____

Child's Name: _____ D.O.B.: _____

Child's Name: _____ D.O.B.: _____

Child's Name: _____ D.O.B.: _____

Child's Name: _____ D.O.B.: _____

Parent Responsible: _____ Phone: _____

Address: _____ Mobile: _____

Email: _____ _____

Please attach a genogram where available

Emergency Contact: _____ Phone: _____

Address: _____ Mobile: _____

Email: _____ Fax: _____

Referred By (Please Attach Mental Health Care Plan):

Doctor's Name: _____ Plan Date: _____

Address: _____ Phone: _____

_____ Fax: _____

Provider #: _____ Email _____

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Health: *Please indicate here any current/previous physical conditions/illnesses or psychological diagnosis:*

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Prescribed Medication: *Please indicate here medications the child is currently taking:*

Medication	Dosage	Frequency	Prescribed by Whom?

Family History: *Please indicate here any known family history of physical (example: epilepsy, diabetes) or psychiatric (example: Manic-depressive illness) disease:*

Relation: _____ Illness/Condition _____

Relation: _____ Illness/Condition _____

Relation: _____ Illness/Condition _____

Trauma History: *Please indicate if you have a history of trauma and the age when this trauma occurred*

Childhood sexual: _____ Ward of state: _____

Adult Sexual Abuse: _____ Neglect: _____

Physical Abuse: _____ Domestic Violence: _____

Natural Disasters: _____ Bullying: _____

Victim of relative Homicide: _____ Cyber safety: _____

War Crimes: _____ Medical complications: _____

Parent was frightening: _____ Parent frightened: _____

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OTHER ASSESSMENTS: *Please provide details on any YES responses, and attach reports)*

Neurological Assessments	☐ Yes ☐ No	Blood tests?	☐ Yes ☐ No
Psychological Testing	☐ Yes ☐ No	Legal issues?	☐ Yes ☐ No
Speech Testing	☐ Yes ☐ No	Family Court Assessments?	☐ Yes ☐ No

WDO Information Required (if Applicable)

License Number: _____ Expires: _____

Fine Reference: _____ Amount _____

Centrelink Payment: _____ Last Amount: _____

CRN: _____ _____

Other Information:

_____

_____

_____

_____

_____

_____