clever care now
live life independently

CLIENT INTAKE FORM

Email Completed Form to : - admin@clevercarenow.org.au

PERSONAL INFORMATION

Full Name : _____ **Gender** ☐ MALE ☐ FEMALE ☐ RATHER NOT SAY

Date of Birth : _____ **Country Of Birth :** _____

Residential Address : _____

Phone Number : (H) _____ **E-Mail :** _____

: (M) _____ **DVA or Pension Number :** _____

Medicare Number : _____ **My Aged Care ID :** _____

Funding Source : ☐ LHD ☐ HCP ☐ CHSP ☐ Private ☐ Insurance ☐ NDIS ☐ DVA

Is the client of Aboriginal or Torres Strait Islander origin ? : Yes ☐ No ☐

Do you concent to us providing your detials to medical professionals or paramedics in the event of an emergency Yes ☐ No ☐

EMERGENCY CONTACT DETAILS / NOK

Contact Name : _____ **Phone :** _____

Relationship : _____ **Email :** _____

Do you hold an Enduring Guardianship or POW ? Yes ☐ No ☐

DOCTOR'S DETAILS

GP's Name : _____ **Phone :** _____

Address : _____ **Email :** _____

REFERRERS DETAILS

Contact Name : _____ **Contact Number :** _____

Relationship : _____ **Email :** _____

Referral Source : ☐ Hospital ☐ GP ☐ Relative ☐ Self Referral

HOPITALISATION HISTORY & SERVICE REQUEST

Hospital Admission Date : _____ **Reason :** _____

Hospital Discharge Date : _____ **Service Commencent Date :** _____

Services Required : ☐ Personal Care ☐ Wound Care ☐ Diabetes Management ☐ Wellness Check ☐ Continence Assessment / Management ☐ Stoma Care ☐ Catheter Care ☐ Physiotherapy ☐ PAS Assessment

Frequency of Visits : _____

Medical Authority Required & Supplied : ☐ Wound Care Authority ☐ Compression Authority ☐ Medication Authority ☐ Catheter Authority

Additional Comments : _____