Eri Care Intake/Referral Form

- Personal Information:
- Full Name:_____
- Date of Birth: _____
- NDIS Number: _____
- Plan Period: _____
- Gender: _____
- Address: _____
- Street: _____
- City: _____
- State: _____
- ZIP Code: _____
- Phone Number: _____
- Email Address: _____
- Preferred Method of Contact: (Phone/Email/Text) _____
- Emergency Contact:
- Full Name: _____
- Relationship: _____
- Phone Number: _____
- Referral Information:
- Referred By: (Self/Doctor/Agency/Other)
- Referrer's Name (if applicable): _____
- Referrer's Contact Information: _____
- Reason for Referral:

  _____

  _____

  _____
- Medical History:
- Primary Care Physician: _____
- Physician's Contact Information: _____
- Current Medications: _____

- Existing Medical Conditions: _____
- Past medical history: _____
- Service Needs:
- Type of Service Required: (e.g., Personal Care, Behavioural Support, Home Assistance, Community access, etc.) _____
- Support Coordination: _____
- Preferred Schedule: _____
- Specific Requests or Preferences: _____

- Provider information:
- Provider Name: Eri Care Support Services
- Address: Shop 5, 168 Scarborough St, Southport QLD, 4215
- E: info@ericaressndis.com.au
- Contact Number: 0435 901 690 – 0470 523 364
- Consent and Agreement:
- I consent to the collection and use of my personal and medical information by Eri Care for the purpose of providing services. (Yes/No) _____
- I agree to the terms and conditions of Eri Care's services. (Yes/No) _____

- Signature:
- Full: _____
- Client's Signature: _____
- Date: _____