

Eri Care Intake 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: _____