

## 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: \_\_\_\_\_