PRE-ADMISSION CHECKLIST			
Client Name:	Age:	D.O.B:	
Address:			
Primary support (if necessary):			
Contact information – Phone:	Email:		
Funding scheme: NDIS ☐ | EPC ☐ | CDMP ☐ | DVA ☐ | Private ☐ | CHCP ☐ |NDIS NUMBER:			
If NDIS, how are they managed? Self-managed ☐ | Agency ☐ | Plan managed☐			
If plan managed, by who? Contact:			
South Burnett ☐	North Burnett ☐	Sunshine Coast ☐	North Brisbane ☐

RELEVANT CLIENT MEDICAL HISTORY
Primary Diagnosis: Autism Disorder
Other Diagnoses:

REQUESTED THERAPY SERVICES						
Occupational Therapy ☐	Speech Pathology ☐	Dietitian ☐	Exercise Physiology ☐	Psychology ☐	Physiotherapy ☐	Nurse (Continence) ☐

HAVE YOU ACCESSED THESE SERVICES BEFORE?
| Yes ☐ | No ☐ |
Do you have access to previous reports? ☐ Please bring them in or email to **conqueralliedhealth@outlook.com**

GOALS FOR THERAPY & FURTHER NOTES

FINAL CHECKLIST
Explain our fees ☐ Explain our cancellation policy ☐ Explain our travel fees (if applicable) ☐
Do you need ramp access? ☐ If so, use the roller door for easier access.
How frequently do you want these services? Weekly ☐ Fortnightly ☒ Monthly ☐ Other ☐ Specify: What is the preferred time of day? After school hours
Before ending the call, don't forget to double check if they know where we are located*
If at any point you are unsure how to answer any client or service specific questions, please ask them to either email them to be answered later or bring them into their initial session with their allied health team member.

Phone: **0408 768 105**
Email: Admin@conquerhealthalliance.com.au