GLENHAVEN
EQUINE CONNECT

glenhavenequineconnect@gmail.com
glenhavenequineconnect.com.au
81 Goodwin Road, Two Mile, 4570, QLD

INTAKE FORM

Date of Referral:

CLIENT DETAILS

Name:

DOB: Age:

Gender: Female Male Other Not stated Prefered Pronouns:

Address:

Home: Safe to call: Yes No
Mobile: Safe to call/text: Yes No
Email: Consent to email: Yes No

NDIS COORDINATOR/PLAN MANAGER

NDIS Number:
Consent to invoice NDIS: (Signature) Yes No

Private Health Insurance Agency:
Private Health Number:

Consent to invoice Health Fund: (Signature) Yes No

Employee Access Provider (EAP):
EAP Number:
Consent to invoice EAP Provider: (Signature) Yes No

EMERGENCY CONTACT

Name:
Relationship to Client:
Contact Number: Consent from client to call: Yes No
Is the emergency contact aware that they are to be contacted in an emergency: Yes No

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Does the client identify as First Nations: Yes No

Aboriginal Torres Strait Islander Not stated

Does client identify as Culturally and Linguistically Diverse: Yes No
Identify Cultural Background:

Interpreter required: Yes No Language:
Do you require any Cultural Considerations/Adjustments to services:

CONSENT

Is the client aware a referral has been sent on their behalf: Yes No
Does the client consent to being contacted: Yes No
Safe to call: Yes No Safe to leave voice messages: Yes No
Safe to text: Yes No

REFERRER

Referring Agency:
Contact Person:
Contact phone numbers:
Contact Email:
Will Referrer continue to provide support to the client: Yes No
Details:

Reason for referral (Please provide as much detail as possible):

PREVIOUS SUPPORT

Have you had Counselling or other psychological support previously: Yes No
Was it for the same issue: Yes No Other:

CURRENT SAFETY/RISK FACTORS IDENTIFIED

Suicidal ideation: Yes No
Details:
(If there is current concerns for safety please contact emergency or acute services)

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Self Harm: Yes No
Details:

Harm to others: Yes No
Details:

Child Safety: Yes No
Details:

Domestic Violence: Yes No
Details:

Substance Use: Yes No
Details:

Other: Details:

Current Supports:

MEDICAL

Disability: Diagnosed: Yes No
Mental Health Issues: Diagnosed: Yes No
Medical Conditions: Diagnosed: Yes No
Medications: (Please list)

Allergies: Animals Yes No Grasses Yes No Bees/wasps Yes No
Other: Please attach Medical Plan if required: Yes No
Do you require: Epipen Antihistamine Other:

(It will be the requirement of the client to provide their own medications and it is expected they will bring them to appointments).
Agreed: Yes No Signature: Date:

Any other relevant information (Please include any trauma symptoms and/or goals for Counselling):

Signature: Date: