EDUCATIONAL CASE MANAGEMENT

CLINICAL ALLIED HEALTH SERVICES

info@ecmonhudson.com 02 4969 8060 www.ecmonhudson.com

OCCUPATIONAL THERAPY CLIENT DETAILS | ADULT

Title: Dr Mr Mrs Ms Master Miss Other:

Last Name: First Name: Middle Name:

Preferred Name: Date of Birth:

Sex: Male/Female/Intersex/Other: Male Female Intersex Other Pronouns:

Do you identify as Aboriginal: Yes No and/or Torres Strait Islander: Yes No

Home Address:

Suburb: State: Postcode:

Mobile No: Work No: Email:

Text: Yes No Email: Yes No Can we leave a voicemail? Yes No

Siblings Name(s) and Ages

Have you ever attended an Educational Case Management clinic? Yes No

EDUCATION / EMPLOYMENT

Do you attend school? Yes No Name of School: Year:

Are you currently undertaking Tertiary Education? Yes No

Are you currently employed? Yes No Place of Work: Occupation:

GENERAL PRACTITIONER

GP Name:

Practice Address:

Phone: Email:

Do you have a Care Plan from your GP or Specialist: Yes No Who has referred you to ECM: GP Specialist

Organisation: Yes No Name of Organisation:

NDIS Provider: Yes No Name of Provider:

INSURANCE INFORMATION

Medicare Card Number: Number on Card: Expiry:

Pension/Health Card Number: Yes No Card Number: Expiry:

Private Health Insurance: Yes No Private Health Provider Name:

Private Health Insurance Card Number Number on Card:

Are you on the National Disability Insurance Scheme Yes No NDIS Number:

NDIS Self-Managed: Yes No NDIA Managed: Yes No PACE Managed: Yes No

Plan Managed: Yes No Please provide Plan Manager's Name:

EMERGENCY CONTACT- LEGAL GUARDIAN/PARENT INFORMATION OR NEXT OF KIN

Full Name: | Relationship to client:

Home No: | Mobile No: | Work No:

Email Address:

Suburb: | State: | Postcode:

Text: ☐ Yes ☐ No Email: ☐ Yes ☐ No Can we leave a voicemail? ☐ Yes ☐ No

FAMILY DETAILS (IF APPLICABLE)

1. Parent/Carer/Guardian Details

Parent Name: | Mobile:

Address:

Family History Mental Health ☐ Yes ☐ No Diagnosis:

Family History Learning Problems ☐ Yes ☐ No Diagnosis:

Are there current Parenting Orders: ☐ Yes ☐ No Please Describe:

2. Parent/Carer/Guardian Details

Parent Name: | Mobile:

Address:

Family History Mental Health ☐ Yes ☐ No Diagnosis:

Family History Learning Problems ☐ Yes ☐ No Diagnosis:

Are there current Parenting Orders: ☐ Yes ☐ No Please Describe:

MEDICAL INFORMATION

Special medical needs, conditions, diagnosis, illnesses, allergies: ☐ Yes ☐ No

Describe:

Medical History:

Are you currently on medication: ☐ Yes ☐ No Current Medication:

Have the following been checked? ☐ Vision ☐ hearing

Does the client require any extra support when attending the clinic? ☐ Yes ☐ No ☐ Communication

☐ Behaviour ☐ Mental Health ☐ Medical Condition ☐ Physical Access ☐ Completing Forms (Easy Read Version) ☐ Interpreter

STRENGTHS AND INTERESTS

Strengths:

Interests

SELF CARE - PLEASE COMMENT ON THE FOLLOWING

Dressing:

Washing:

Hair:

Brushing Teeth:

Eating:

Drinking:

Toileting:

Other:

GROSS MOTOR SKILLS

Have difficulty learning new motor skills?	Yes	No
Enjoy sport / group games?	Yes	No
Clumsy?	Yes	No
Play ball games?	Yes	No
Can run / jump / climb?	Yes	No
Any other gross motor concerns?	Yes	No

Describe:

FINE MOTOR SKILLS

Hand preference	R	L
Difficulty with the following?		
Cutlery	Yes	No
Buttons / zippers	Yes	No
Shoe laces	Yes	No
Cutting	Yes	No
Colouring	Yes	No
Handwriting	Yes	No
Ever complain of pain or fatigue when engaging in tasks with hands?	Yes	No

SENSORY PROCESSING

Have you ever noticed reacting differently to others with the following? If yes, please provide example

- Touch:
- Smell:
- Taste:
- Sound:
- Sight:
- Movement:
- Awareness of self in space:

OTHER CONCERNS

Do you have any concerns regarding the following? If yes, please provide details

- Attention:
- Listening:
- Aggression:
- Violence:
- Meltdowns:

MORE ABOUT YOU

How do you prefer to interact?

Do you have friends?

Do you have any special interests?

Do you have any dislikes?

If you could change three things what would they be?

1.

2.

3.

BANK DETAILS (AUTOMATIC PAYMENT FOR SERVICES)

Bank Account Name:

Bank Account Number: BSB Code:

Or

Credit Card (Name on card): Expiry Date:

Card Number: CVC:

Fees:

Fees (consultations, telehealth, therapy, groups, reports, and resources) are payable at the time the service is provided. A $80.00 deposit is required when the initial consultation is scheduled by the Administration Team. Fees will vary depending on Allied Health Professionals discipline hourly rates ranging from $185 to $270. Report fees will depend on Allied Health Professionals discipline hourly rates and will be governed by a time frame from 1 hour (Summary Reports) to 12 hours (Psychological, Functional and/or Behavioural Reports). Supports for participants under the National Disability Insurance Scheme (NDIS) will be subjected to NDIS Pricing Arrangements and Price Limits 2024-2025- charged at the hourly rate specified for each discipline. Please visit https://www.ecmonhudson.com for information regarding Allied Health Professional Services and Fees.

Cancellation Policy:

ECM has put in place a cancellation policy to ensure that enough time is provided to offer the appointment time to another client. If less notice is provided, other clients may miss out on obtaining the services they require. Amendments to appointments must be made via phone (02 4969 8060) or via email (info@ecmonhudson.com) and must be made within 2 business days of the appointment scheduled. A Debt Collection service may be used to collect outstanding debts if not paid. A 100% consultation fee will occur if ECM is not notified within 2 business days. This also applies to participants supported by the NDIS and includes cancellations, rescheduling, or failure to attend appointments.

Privacy and Confidentiality

All personal information, assessment results, and documentation collected by ECM Allied Health Professionals is confidential. All documentation is stored securely and locked with Zanda Management password system and Authenticator, and can only be accessed by the ECM clinicians treating the client and/or administration team who are also bound by confidentiality.

Limitations to confidentiality

All personal information gathered by the therapist during the provision of therapeutic services will remain confidential except when:

1. It is subpoenaed by a court; or
2. Suspected or reported risk of harm to self or others (i.e. suicidal or self-harm ideation/plan/intent; homicidal ideation/plan/intent); or
3. Criminal act requiring reporting to the Policing Services; or
4. Current alleged or actual observed abuse, harm or neglect to a client requiring reporting to authorising bodies as per NDIS Practice Standards (this could include, for example, Child Safety/ Protection bodies across States and Territories or the NDIS Quality and Safeguarding Commission); or
5. Your prior approval has been obtained to: a. provide a written report to another professional or agency. e.g. GP, school or a lawyer; or b. discuss the material with another person, e.g. a parent, employer or health provider; or c. disclose the information in another way.

Please note ECM are mandatory reporters and obligated to report ALL suspicions and allegations of abuse. GP's require review letters throughout the year that often include a summary of sessions. For those on the NDIS, it is a requirement to provide (at a minimum) a progress report at each review stage.

Emergency Contacts

Please note we are not an emergency service; our phones and emails are not constantly monitored. In an emergency situation please contact 000 for police/ambulance.

- Police or Ambulance - 000
- Mental Health - 13 14 65 Lifeline - 13 11 14 or www.lifeline.org.au
- Kids Helpline (5-25 years) - 1800 55 1800 or www.kidshelpline.com.au
- Suicide call back service - 1300 659 467 or www.suicidecallbackservice.org.au

Please email info@ecmonhudson.com or call 02 4969 8060 if you have any questions about this form. Please bring all reports and relevant information to your initial consultation.

I (Print Name) ☐ give / ☐ do not give permission for ECM to Forward the ECM Newsletter and updates to the recorded email address.

CONSENT

I (Print Name) confirm that I have read the information and that information provided is accurate to my knowledge. I consent for ECM to provide treatment &/or service, retain information on their secured and confidential data base and share (if necessary) with Medical Practitioner/Specialist for the purpose of reporting on a condition after assessment and/or treatment (if required).

I have signed the Informed Consent form

☐ Yes ☐ No

Client Signature: Date:

If client is under 18 years of age Parent/ Carer/Guardian/Responsible Person:

Name: Signature: Date: