saexp
Exercise Physiology

Initial NDIS Consultation Form

Your personal information is used for the following:

1. Accounting and administration to comply with health fund and health insurance requirements
2. Disclosure of information to other health professionals involved in your care; ie (general practitioner, specialists and other allied health professionals) or external audit if required.
3. Quality assurance within SAEXP

Mr/Mrs/Ms/Miss/Mst/Dr (**Please Circle)** Date of birth: _____ /_____ /_____

First name: _____ Surname: _____

NDIS number: _____

Address: _____ Postcode: _____

Preferred contact number: _____

Email Address: _____

Occupation: _____

Name of emergency contact: _____Contact number: _____

Carers Contact Details (if applicable):_____

Medicare No: _____ Ref #: _____ Expiry date: __ /____

Private Health Fund: _____ Membership no: _____

Family Doctor: _____

Other Allied Health: _____

NDIS Plan Information

Management: **(Please circle)** – Self managed or Plan managed or NDIA managed

If plan managed, please provide:

Company name: _____

Representative: _____ Contact:_____

Support Coordinator (Name and contact): _____

NDIS Start Date: _____ NDIS End Date: _____

Support Category: _____

A: 8-9/54-58 Kilby Rd Kew East 3102
P: 9996 9599
E: admin@saexp.com.au

NDIS Plan Goals

Condition for NDIS participation: _____

Participant Needs: _____

_____

_____

Plan goals: _____

_____

_____

Individual Risk assessment:

Please specify: Communication barriers, cognition, mobility, personal care, manual handling, behavioural history.

_____

_____

_____

Additional information:

_____

_____

_____

Privacy Policy:
SAEXP's privacy policy statement may be obtained on request.
I understand that in order to most safely and effectively prescribe you exercise SAEXP needs to collect medical and personal information from you. All information collected is strictly confidential and will only be used in the circumstances highlighted on the previous page.

I consent to assessment and prescription of exercise and understand that all modalities of exercise including aerobic and resistance training may leave me with post exercise soreness. I will provide all the relevant information about my health and medical history. I intend this consent to apply to all my present and future Exercise Physiology sessions and for administrative purposes.

_____ _____ _____/_____/_____

Print name **Signature** **Date**

WHERE PARTICIPANT IS UNDERAGE OR GUARDIAN IS REQUIRED

I, _____ being the parent or guardian of the person named, **hereby acknowledge and agree** I have read the whole of this document and understand it. **In consideration of** the person named in this form, I provide my consent for the participation of assessment and prescription of exercise.

_____ ___/_____/_____

Signature of parent/guardian **Date**

A: 8-9/54-58 Kilby Rd Kew East 3102
P: 9996 9599
E: admin@saexp.com.au