|  |
| --- |
| **Participant Intake Form** |

**Participant Details**

|  |  |
| --- | --- |
| **Participant’s name:**  |  |
| **Date of birth:** |  |
| **Identifies as:** | [ ]  **Female** [ ]  **Male** [ ]  **Non-binary** [ ]  **Other**  |
| **NDIS Number:**  |  |
| **Phone details:**  | **Home:** |  | **Mobile:** |  |
| **Email address:** |  |
| **Language spoken at home:** |  | **Interpreter required:** | [ ]  **Yes** [ ]  **No**  |
| **Preferred option for communication:** | [ ]  **Email** [ ]  **Post** [ ]  **Phone** | Identifies as Aboriginal and Torres Strait Islander? [ ]  **Yes** [ ]  **No** |
| **Residential Address:** |  |
| **Postal Address** *(if different from above)* |  |

Is there a Guardianship and/or Administration order in place? [ ]  **Yes** [ ]  **No**

Is there a Behaviour Management Plan in place? [ ]  **Yes** [ ]  **No**

Provide the following information for participants under the age of 18, under guardianship or in the care of family or caregivers.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Parent/Guardian 1:**  |  | **Primary Carer?** | [ ]  **Yes** | [ ]  **No** |
| **Lives with Participant?**  | [ ]  **Yes** | [ ]  **No** |
| **Emergency Contact?** | [ ]  **Yes** | [ ]  **No** |
| **Relationship to participant:** | [ ]  **Parent** [ ]  **Guardian** [ ]  **Caregiver** [ ]  **Other** |
| **Residential Address:** |  |
| **Postal Address** *(if different from above)***:** |  |
| **Phone details:**  | **Home:** |  | **Mobile:** |  |
| **Email address:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Parent/Guardian 2:**  |  | **Primary Carer?** | [ ]  **Yes** | [ ]  **No** |
| **Lives with Participant?**  | [ ]  **Yes** | [ ]  **No** |
| **Emergency Contact?** | [ ]  **Yes** | [ ]  **No** |
| **Relationship to participant:** | [ ]  **Parent** [ ]  **Guardian** [ ]  **Caregiver** [ ]  **Other** |
| **Residential Address:** |  |
| **Postal Address** *(if different from above)* |  |
| **Phone details:**  | **Home:** |  | **Mobile:** |  |
| **Email address:** |  |

**Disability/Medical Conditions including diagnoses** (*if applicable)*

|  |
| --- |
| 1. |
| 2. |
| 3. |

**Medication/s Required**

|  |  |  |
| --- | --- | --- |
| **Medication Assessment Tool** | **Strategies Developed** | **Identified in Support Plan** |
| Medication Plan and Consent Form | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| Medication – Self Medication Assessment | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| Medication Risk Indemnity Form | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |

**Behaviour Support**

Behaviour Support Plan documents collected for authorisation purposes [ ]  **Yes** [ ]  **No**

(if relevant)

Behaviour Support Plan available on NDIS portal? [ ]  **Yes** [ ]  **No**

**Other Service Providers**

*(include Specialist Behaviour Support Provider, if relevant)*

|  |  |
| --- | --- |
| **Organisation Name:**  |  |
| **Address:** |  |
| **Phone Number/Email:** |  |
| **Frequency of Use:** |  |

|  |  |
| --- | --- |
| **Organisation Name:**  |  |
| **Address:** |  |
| **Phone Number/Email:** |  |
| **Frequency of Use:** |  |

**Health Care Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medicare Number:** |  | **Expiry Date:** |  |
| **Reference Number:** |  |
| **Private Healthcare Provider:** |  | **Membership Number:** |  |
| **Reference Number:** |  |

|  |  |
| --- | --- |
| **Doctor’s Name:**  |  |
| **Address:** |  |
| **Phone Number:** |  |
| **Email Address:** |  |

**Funding**

[ ]  **NDIA-Managed** (A copy of the NDIS plan must be provided for NDIA-Managed participants)

|  |  |
| --- | --- |
| **NDIS Number:** |  |
| **NDIS Date:** |  |

[ ]  **Self-Managed** [ ]  **Plan-Managed**

Provide details for invoices

|  |  |
| --- | --- |
| **Name:** |  |
| **Email:**  |  |
| **Additional Information:** |  |

**Personal Preferences**

|  |  |
| --- | --- |
| **Preferred Name:** |  |
| **Religious Requirements:** |  |
| **Cultural Requirements:** |  |
| **Communication Aid:**  |  |
| **Physical Assistance:** |  |
| **Other Considerations:**  |  |

**Personal Goals**

|  |
| --- |
| **Describe your personal goals – life skills, physically, socially?** |
|  |
| **When do you want to achieve your goals?** |
| **Immediately:**  |  |
| **In 6 months:** |  |
| **Next year:** |  |

**Risk Assessment**

|  |  |  |
| --- | --- | --- |
| **Risk Assessment Tool** | **Strategies Developed** | **Identified in Support Plan** |
| Individual Risk Assessment Profile | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| Safety Environment Checklist – Home | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| Participant Safe Environment Risk Assessment | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| Nutrition and Swallowing Risk Checklist | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |

**Participant Acknowledgment**

I understand that:

* Sincerity Support Services (VIC) PTY LTD owns these records.
* Information within these records will be shared with other relevant workers within the organisation only when the relevant worker requires the information to carry out their duties and provide safe and quality services and support.
* I can ask to see my personal records at any time and receive a copy for my records.
* My personal records are archived for a set period according to legislative and organisational policy requirements.
* I understand that all information obtained will be kept secure, private and confidential.

To the best of my knowledge, the information provided in this form is true and correct:

|  |  |
| --- | --- |
| **Participant’s Signature:**  |  |
| **Authorised Representative’s/Parent’s Signature** *(if applicable)* |
| **Name of the Person Signing:** *(if not the participant)* |  |
| **Relationship to the Participant:** (*if not the participant)* |  |
| **Date:** |  |

**Note:** Authority to Act as an Advocate form is required if the individual signing this form is not the participant.